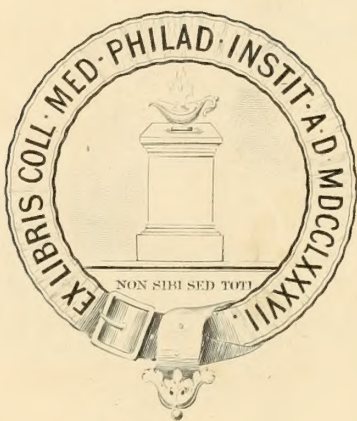





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D. W. YANDELL, M. D., AND H. A. COTTELL, M. D., EDITORS

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*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.*—RUSKIN.

## Original Articles.

### REPORT OF ELEVEN CASES OF ATYPICAL TYPHOID OR TYPHO-MALARIAL FEVER.\*

BY T. B. GREENLEY, M. D.

Until September of the present year I had not seen a case of protracted fever of a typhoid type since the winter of 1884-85, with a single exception. That was a case of typhoid which occurred in October, 1885.

On September 10th I was called to see Mr. S. S., the first of eleven cases occurring in my practice the present fall. This patient had been troubled over two months with diarrhea during the summer, but was relieved several weeks previous to this attack. He also had an attack of remittent fever about two weeks before, which was of short duration, and for which I visited him once. He endeavored to work about a week between the two attacks. When first seen in the last attack I regarded it as a re-attack or relapse of remittent, and prescribed accordingly. In remittent, uncomplicated, I always expect to break up the fever in forty-eight hours, and having left sufficient medicine for that length of time, and on my second visit, two days after, finding his fever still quite high, 103.5° F., was apprehensive of typhoid trouble. I now, with some hope of arresting the fever, prescribed quinine and Dover's powder freely every four hours for two days longer. This was on the 12th. On

the 14th, my third visit, the fever was as high as ever, when I was fully convinced I had to deal with a case of protracted fever.

Never having seen any evil effects from the use of antifebrin, I combined grs. ijs with quinine grs. v and Dover's powder grs. v, to be given at intervals of six hours. Up to this time no phenomena had supervened to convince me of its typhoid character, except the persistency of the fever. This was on Friday, about noon, and the patient's wife not being in, I directed him how to take the medicine, and said I would see him again on Sunday morning. On Saturday afternoon he got up and went out of doors; when he got back to bed he fainted and never revived. I am more particular in describing this case on account of its unexpected unfortunate termination. Now what part, or any, did the small doses of antifebrin play in causing death from heart failure? The patient was greatly reduced in strength from having had diarrhea during the summer, together with the slight attack of remittent fever a short time before. Although I noticed no tendency to heart failure at my last visit, its giving way possibly may have been aided by the antifebrin. At all events I have concluded, in the future, not to prescribe it under similar circumstances, unless I exercise supervision of its effects.

It was remarked by those present that the patient seemed better and talked quite pertly just before he got up.

CASE 2. Mrs. M., aged twenty-three years, married, and naturally delicate. This patient was pretty well worn down by nursing her youngest child with dysentery, and had complained of headache and general bad feelings for more than a week before she took her bed. The disease was developed by

\* Read before the Hardin County Medical Society, December, 1888.

a pronounced chill. When I saw her she had six degrees of abnormal heat. This was on September 26th, and for three weeks her temperature ranged from  $102.5^{\circ}$  in morning to  $104^{\circ}$  in the evening, unless directly under the influence of antipyretics.

I gave her in the outset quinia and Dover's powder, of each grs. v, at intervals of four hours, in order to, if possible, arrest the fever; but on the third day, there being no amelioration of the disease, I changed the intervals to six hours, with the addition of antifebrin, grs. iv. This prescription usually produced diaphoresis, but most antipyretics only reduced the temperature temporarily. This patient was kept on this treatment about one week, but the fever would always come up as soon as the influence of the medicine abated. I now left off the antifebrin and substituted resorcin, which, with the quinine and Dover's powder, was given every six hours. In two weeks from the commencement the temperature was not so hard to control—ranging from  $2.5^{\circ}$  in the morning to  $4^{\circ}$  in the evening of abnormal heat. The case continued in this way two weeks longer, when the temperature gradually came down to  $1.5^{\circ}$  in morning and  $2.5^{\circ}$  to  $3^{\circ}$  in the evening, and at the end of the sixth week there was no excess of temperature in the morning, and only  $1.5^{\circ}$  in the evening. At the end of six weeks and four days the patient was entirely clear of fever. The disease in this case was more protracted than any in the group I am reporting. She kept her strength wonderfully well to the last, and was able to sit up fifteen minutes at a time the day after the fever left. She had a good appetite all the time, and received due nourishment in the way of milk, soup, etc.

CASE 3. September 28th. Called to see W. K., aged twenty-five, stout and naturally healthy. Had been unwell for several days, having got wet and allowed clothes to remain unchanged. Temperature  $103^{\circ}$ , pulse 88; cough, due to bronchial irritation. Quinine and Dover's powder, each grs. v, every four hours.

29th. Temperature and pulse same as yesterday. Continued treatment.

30th. Finding no diminution in temperature, I put him on quinine, Dover's powder, and salicylate of ammonium, grs. v each, at intervals of six hours. This treatment was kept up ten days, when his fever had measurably abated, morning temperature being normal, and evening  $100^{\circ}$ ; at end of two weeks the fever entirely disappeared. His appetite was good, and he was allowed milk and soup freely. He recovered rapidly.

CASE 4. H. S., aged thirty-four; a stout and healthy man. Saw him October 16th. Said he had not been well for eight or ten days. Temperature  $104^{\circ}$ , pulse 100. Bronchitis, attended with severe cough. Treated him two days with quinine and Dover's powder, each grs. v, every four hours.

On the 18th, temperature and pulse being same, added ammonium salicylate and lengthened intervals to six hours. In ten days temperature reduced to  $99^{\circ}$  in morning and  $101^{\circ}$  in evening, and at end of two weeks fever had entirely abated. His appetite kept good and he received due quantities of milk and soup. He made a good recovery.

CASE 5. H. F., aged seventeen; naturally delicate. Got wet a week ago, allowing clothes to remain on him. Called to see him October 19th. Temperature  $103^{\circ}$ , pulse 90; cough, due to bronchitis, with bloody expectoration. Same treatment as in preceding cases. In two weeks temperature became normal in morning with an evening rise of two degrees. This continued nearly a week, and we thought he would soon be well; but about the end of the third week the fever began to increase, with morning rise of  $1.5^{\circ}$  to  $2^{\circ}$ , and evening of  $3^{\circ}$  to  $3.5^{\circ}$ , which continued a week and then gradually increased up to the 20th of November, when he died. A few hours before death his temperature was  $104^{\circ}$ . There were several circumstances attending this case which militated very much against his recovery.

In the first place his surroundings, in a sanitary point of view, were bad. There were some six families in the house, an old hotel building, with a dozen or more children, and in bad weather they kept up a continual racket, which greatly fretted the

patient. These families cooked and washed in the house, and, not being observant of any great degree of cleanliness, there was a very unpleasant odor generated, which was very palpable to the olfactories of any one on entering it.

He had no appetite, and what little nourishment he got was taken with a great deal of reluctance. A material back-set was brought about by eating a very sour orange, which produced an attack of cramp colic. He really never rallied from it, complaining very much of soreness through his bowels. His fever rose two degrees on account of the attack, and I was never able to get his evening temperature to where it had been. Seeing the case would, under the circumstances, terminate fatally, I had him moved out of the old house on the 19th, affording him that slight chance for his life. This should have been done before, but no house could be obtained.

Up to the third week I regarded this case as of a mild character, and was firmly of the opinion he would get well.

CASE 6. October 19th. Was called to see C. M., aged thirty, in same house as Case 5. Had been sick several days before I saw him. He got wet working in rain, allowing his clothes to remain on him.

Temperature 103°, pulse 90; cough, result of bronchitis. Treatment in outset as in preceding cases. After pushing quinine, etc., for two days and finding temperature unchanged, I put him on quinine, Dover's powder, and salicylate of ammonium, each grs. v, at intervals of six hours.

October 21st. Temperature 103°, pulse 90; bronchitis subsiding and cough ameliorated.

22d. Condition same as on yesterday. Treatment continued. The temperature and circulation remained about the same up to the end of the first week, and then the temperature began to recede until end of the second week, when the morning temperature became normal, while in the evening it was 2.5° to 3° above, and gradually diminished until, at end of the third week, he was clear of fever and dismissed.

CASE 7. J. B., aged fifty, of usual good health, had been feeling unwell several days. First saw him on 29th October. Temperature 100° in the morning and 103° in evening, pulse 80 to 84. This patient had the lowest temperature in the morning of any of the preceding cases. Like the others I endeavored to abort it with quinine and Dover's powder, each grs. v, every four hours, but the treatment had no permanent effect. I then exhibited quinine, Dover's powder, and resorcin at intervals of six hours. On this treatment in ten days morning temperature was normal, and at the end of two weeks the fever disappeared.

CASE 8. Mrs. K., wife of Case 3, aged twenty-three. She has enjoyed fairly good health heretofore, but was complaining several days before I saw her, November 2d, with headache and chilly feelings. Temperature 104.5°, pulse 100; headache. Quinine, Dover's powder, and salicylate ammonia, each grs. v, every four hours for two days.

November 4th. Temperature 104° in evening, with pulse 100. Continued treatment at intervals of six hours, with sponging extremities with tepid water to aid in reducing temperature.

November 9th. Temperature 102° in morning and 103° in evening. Treatment continued.

November 16th. Temperature 101° morning and 102.5° evening. Treatment continued, except sponging.

November 23d. Temperature 101° morning, 102.5° evening. Treatment continued, with addition of grs. ijss antifebrin at noon and evening to aid in reducing evening temperature.

December 1st. Temperature in morning 99.5°, evening 100.5°. Treatment continued.

December 5th. Temperature normal morning and evening. In this case the fever continued four weeks and five days, and she was able to sit up a few minutes every morning while her bed was made up. I think this was due to the amount of nourishment received daily. Her appetite was good and she was always ready for her food, which consisted mainly of milk and soup.

CASE 9. November 6th. W. D., aged twenty, has been sick two or three days, feeling chilly, with headache. Had taken several doses of quinine. Up to this time has enjoyed fairly good health. Temperature in morning 100°, evening 102°, pulse 80. Treatment same as in other cases for first two days, and afterward, every six hours, with addition of salol grs. v. This patient had the mildest attack of any as far as temperature was concerned. At the end of the first week, morning temperature 99°, and evening 101°, and at end of two weeks the temperature was normal.

CASE 10, same as Case 7, who had been up a week and relapsed on account of an undue amount of exercise. Called to see him November 15th in his second attack. Temperature 102.5°, pulse 80. I again pushed quinine and Dover's powder for forty-eight hours, hoping his trouble might be of a remittent character. But his temperature was the same at expiration of that time. I now continued the treatment at intervals of six hours with addition of salicylate ammonia, grs. v. At expiration of ten days, morning temperature was normal, but evening temperature 101°, which in four days more left him, and continuing medicine two days longer, dismissed him.

CASE 11. C. B., aged twenty-three, and son of Case 10. Delicate constitution. Had an attack of remittent fever some two months ago. Saw him November 27th. Temperature 102°, pulse 112. Owing to his pulse being more frequent than any case I had seen, I hoped this might be a second attack of remittent. Gave quinia and Dover's powder, each grs. v, every four hours. November 28th, temperature in morning 100.5°, evening 102, pulse 108. Continued treatment. November 29th, temperature, in morning 101.5°, evening temperature, 102°, pulse 104. Continued treatment. November 30th, temperature 100°, evening temperature 102°, pulse 90. As this is third day in which he has taken quinine and Dover's powder every four hours, without reducing the evening temperature, I now changed treatment to intervals of six hours, with addition of five

grs. of am. salicylate, which treatment was continued until December 6th, when the fever had entirely disappeared. This patient was under treatment only ten days, but was sick several days before I saw him.

Owing to the absence of certain symptoms which characterize typhoid fever, I headed this paper with the term *atypical* typhoid or typho-malarial fever. I got the idea from a paper read by Dr. Dabney before the Medical Society of Virginia at its late meeting. He contended that, though some of the most prominent symptoms were lacking, yet the disease was really typhoid fever, from the fact that the cases presented some of the distinctive symptoms, as hemorrhage, intestinal lesions, as learned on autopsy, and that it prevails at times as an epidemic. He claims that the disease in this country is becoming milder, and thereby eliminating some of its former symptoms. That on this account the diagnosis is often attended with difficulty, and in the early stages is impossible; that in cases extremely mild dangerous symptoms may arise suddenly, and a fatal issue ensue from imprudence in diet or otherwise.

The cases above reported were different from any thing in the fever line that I recollect of seeing. In fact they virtually resembled neither typhoid nor typho-malarial fever in any special characteristic save the persistency of the fever. There was no nervous stage in any case, except in second case slight mutterings occasionally while asleep. There was no persistent diarrhea in any case, and only a tendency to that complication for a short period in two of the cases. In fact constipation rather was the rule. Hemorrhage of any description did not occur in a single case. In fact bronchitis was the only complication independent of the fever which occurred in four cases, and which could be accounted for by exposure previous to the development of the disease.

As to the course of treatment I pursued in this fever, I admit it was somewhat empirical as well as expectant. But I believe, upon the whole, it is as good as any. I tried in various cases to abort it by quinine

and other antipyretics, but failure was invariably the result. In fact I regarded it as somewhat hazardous to push antipyretics to a very great extent on account of the slow action of the heart.

Dr. Barnett, of Wisconsin, in a recent paper published in the *Journal of the American Medical Association*, claims for salicylate of ammonium almost a specific in typhoid or remittent fevers. He claims to have treated a number of cases successfully with this remedy by aborting them in the early stage. While, on the other hand, Dr. Jackson, of Virginia, in a late paper read to the Medical Society of Virginia, claims that it is not so well adapted to typhoid fever as it is to that of a malarial character, and also affirms that the nitrate of ammonia is a much better remedy in typhoid troubles. He lays down a principle that the carbon compounds, as a rule, should be used in treating malarial fevers, while nitrogen compounds are better adapted to the treatment of typhoid fever. He has used this treatment in his practice forty years, and has on more than one occasion called the attention of the profession to the fact of their virtues.

As to the cause of this character of fever I am entirely unable to surmise. I examined the premises where it prevailed, and could discover nothing which I could regard as a factor in its development, except at two, and at these I am of the opinion the inmates had not been residents sufficiently long to contract the disease on account of their unsanitary condition before its development. During its prevalence I saw nothing in its history to induce me to believe in its contagious character.

All of the cases occurred in the town of West Point except Case 1.

WEST POINT, KY.

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THE INTERMITTENT GALVANIC CURRENT is said by Dr. J. R. Seymour to be efficacious in case of sting by the physalia (Portuguese man-of-war). Perhaps it might be efficacious also in other cases of poisonous and painful stings.

## RUPTURE OF THE UTERUS DURING LABOR.\*

BY T. L. M'DERMOTT, M. D.

I have concluded to report the following case of rupture of the uterus, principally from the fact that the occurrence is very rare, and that no similar case has been reported to this Society. Statistics would indicate that it occurs once in about five thousand cases, although the history of the subject in this city would show it to be less frequent. Still it may fall to the lot of any member at no remote time, and the discussion of its details may serve him in great need in this, the most terrible of all the accidents that pertain to the parturient state. The confrontation of such a disaster without a careful study of the means for its relief, which must of necessity be immediate, is likely to leave the average practitioner in such doubt that the opportunity is passed which gives the only promise of safety to his patient.

While the accident is so rare that but a few cases have demanded the attention of the profession here, still I can understand, when we consider the various causes that may provoke it, how a skillful manipulation of a predisposed case might avert the accident. It has occurred to me on one or two occasions to be in attendance on patients who, though of vigorous habit, endured such agonizing throes of labor that I was induced to use the forceps to prevent this very danger. Taking the maxim to be a wise one, that to be forewarned is to be forearmed, I believe it has no more forcible application than in this case I am reporting. And while we are prone to magnify the dangers that environ the parturient state, the discussion will familiarize us with the details of this catastrophe in such a striking way that we may be at a loss to determine what is best for our patient, independent of any consideration of the wishes of family or friends. (In parenthesis I must add that it transpired in this instance that a false regard for the

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\*Read before the Louisville Medico-Chirurgical Society, November 30, 1888. For discussion see page 7.

wishes of her immediate relatives prevented the only means of relief for the woman.)

I was called at 1 A. M. to see Mrs. Mack, February 19, 1888, who was then in charge of a midwife. I found her considerably prostrated, and got an indefinite history of a labor that had been progressing for some time. Faint uterine contractions, upon examination, revealed two things: First, that the child was almost out of reach of the finger, and upon contraction small oozing of blood would occur. Inspection abdominally revealed the fact that the abdominal tumor had almost entirely disappeared, and the child could be felt through the parietes by palpation. She was a woman of apparently robust health, but had endured considerable hard-hips and had borne nine children previously. She had been having intermittent labor pains for nine or ten days, during which she had sent for a midwife. The membranes had been ruptured, if we can believe their report, for over a week. Whether any medicine or violence was used by the midwife, we could not learn by inquiry. At this time I doubt if the rupture was complete, for there was still faint contraction and a slight loss of blood with each pain. I informed the family of the gravity of the case and asked for a consultation, which was accorded. Dr. W. H. Wathen was summoned, and a laparotomy was considered the only alternative. Dr. W. O. Roberts was then suggested by a member of the family to do the operation, and he was hastily summoned. At this time, and in fact for some time previously, the prostration was so profound that after consultation it was determined the woman could not survive the shock of the operation. We waited patiently by her bedside, applying restoratives until 4:30 A. M., when I suggested, as her condition precluded any interference, that we would leave her with her spiritual adviser, and left instructions to have me called if she rallied. I slept a few hours at an adjacent hotel within easy reach, and was called again about 7 A. M. Upon my return I found the pulse better, sweating had disappeared, in fact all symptoms of collapse were gone. I

called Drs. Wathen and Roberts hurriedly, and we were prepared for the operation; but the husband in the mean time had left the house and did not return for an hour later, and we were deterred from operating both by his relatives, who were present, and the instructions of the husband, who was absent. I believe Dr. Roberts will bear me out when I say that I insisted on proceeding, but we felt that under the circumstances nothing was left us but to consider their wishes. If it should occur to me again to meet a similar case, I would direct such efforts as seem demanded independent of the wishes of any one except the patient herself. And I think the lesson of the case teaches us, in the light of its retrospection, that, while we might not have saved the patient, we deferred our judgment to a false regard for the views and wishes of the family. At my request Dr. Wathen turned and delivered the child and membranes. The woman expired some two hours later. The rent was on the left side of the uterus, extending from the os externum to the middle of the fundus. No hemorrhage or shock attended the delivery of the child. No ergot had been administered, and I believe the rupture to have been due to degeneration of the uterine walls consequent upon a life of toil and rapidly consecutive pregnancies. Abdominal section with removal of the entire uterus was, I think, the only means that could offer any hope of saving the woman; the child had apparently been dead some time. I believe the death returns in cesarean section under the improved methods, with antiseptics, irrigation, etc., shows only a mortality of twenty per cent. In sixteen operations, reported from Leipsic by Säger and others, there were fifteen recoveries, the children all being saved. Of course I leave the discussion of such operations to those who have given the subject more attention, feeling that I have done my duty when, meeting the emergency as I did, I intrusted to other hands the details of its successful prosecution. It is pleasant to record, in connection with this case, that in the retrospect of a long experience, in which

I have encountered nearly every phase of the vicissitudes of the child-bearing period, this is the only fatal case with which it has been my lot to be associated; not that I mention it of any interest to myself, but that nature in her wise munificence accords so much safety to the parturient state.

LOUISVILLE

## Societies.

### LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting November 30, 1888, Dr. Turner Anderson, M. D., President, in the chair.

Dr. T. L. McDermott read the essay of the evening, subject, Rupture of the Uterus, with a report of a case. (See p. 5.)

#### DISCUSSION.

Dr. John G. Cecil said that delay in operating when this accident occurs is not necessarily fatal to the woman, in proof of which he referred to a case in the practice of Dr. J. N. McCormack, in which the operation was not done until after twelve days. The woman died of intercurrent trouble, which was in no way connected with the rupture or the operation.

Dr. Skinner counseled immediate operation, and agreed with the essayist that the surgeon should not await the consent of the family in such a case.

Dr. H. K. Pusey believed, that in view of of the serious consequences which might follow, the surgeon would not be warranted in taking into his own hands the full responsibility of the operation.

Dr. F. C. Wilson said that the first duty of the obstetrician in such a case was to turn and deliver the child, and that this should be done without awaiting a consultation. Before operating, however, he would take counsel and get the consent of the family.

Dr. W. L. Rodman said the surgeon should not operate under the circumstances against the wishes of the family.

The President said that in twenty-three

years of practice he had seen but one case of rupture of the uterus. In this he was called in consultation, but arrived half an hour after the occurrence of the accident. At this time the patient was dead. She was a multipara, belonged to the working class, and had been for sometime previous to labor submitted to great mental worry. The labor had been tedious. At the time he favored cesarean section with a view to saving the child, but the objections of the family could not be overcome, and nothing was done. The rupture had occurred during the acme of a pain; shock and hemorrhage had caused the sudden death. The speaker considered multiparity to be the most important predisposing cause, especially when associated with acute or chronic uterine disease. The rupture may be either complete or incomplete; it has been known to occur during pregnancy before the commencement of labor. As to symptoms, hemorrhage is constant; with this there is usually shock, arrest of uterine action, and recession of the presenting part. Treatment by version, when the child has in part escaped through the rupture into the abdominal cavity, is not advised by recent writers. The course best pursued under such circumstances is laparotomy. Whether the operation should be done at once or delayed until the patient has rallied from shock, is a very important question. The speaker favored the primary operation. Ether should be employed as an anesthetic, because of its stimulating effects.

Dr. McDermott said, closing the discussion, that his case gave little evidence of hemorrhage. If he were to meet with the accident again, he would still favor primary laparotomy.

Dr. W. L. Rodman reported the following case:

Early in the night of November 16th he was asked by Dr. Turner Anderson (the doctor being unable himself to go) to see a girl seventeen or eighteen years of age, who was suffering with uterine hemorrhage. The loss of blood had been so great that the patient was well-nigh exsanguinated.

She was in the seventh month of pregnancy, and this was the third hemorrhage she had sustained in three weeks. Examination showed the os to be undilated. He tamponed the vagina to arrest the hemorrhage. This was at 9 o'clock p. m. At 12 o'clock Dr. Anderson saw the case with the speaker. The os being still undilated, Dr. Anderson dilated it to a considerable extent by means of the finger, but without inducing uterine contraction. After twenty minutes the head could be easily reached, and the case was found to be one of accidental hemorrhage. It was now determined to bring on labor by rupture of the membranes. There was no bagging of the water. A sound was introduced and the membranes ruptured. The vagina was again tamponed, and the patient allowed to rest until 9 o'clock next morning. At that time no labor pains had begun, nor did they come on until 3 o'clock A. M. next day. Two hours afterward she was delivered. The child died after a few hours, but the mother made an uninterrupted recovery. Examination of the placenta showed that it had been partially detached. This was doubtless the cause of the hemorrhage. According to Goodell, in such accidents nearly all the children and half the mothers die.

Dr. Cecil asked by what appearance of the organ it had been determined that the placenta had been partially detached. Dr. Rodman said that this was indicated by a patch on the attached surface of the organ, differing from the rest of this surface in color and other characters. This patch unquestionably represented the point of detachment.

Dr. Wilson suggested that it would have been better in this case to have attempted to induce labor without rupturing the membranes, since this method would have conduced to the safety of the child.

Dr. Anderson said that in accidental hemorrhage occurring in primiparæ (and such was this patient), with absence of uterine action, there was usually great difficulty encountered in attempts to dilate the os. He had succeeded in this and in other cases by

fixing the head by counter-pressure and using the finger as a dilator. The important question in dealing with cases of this kind is, what procedure gives the best chances of saving both the mother and child? He had ruptured the membranes in this case for the double purpose of lessening the danger of further hemorrhage and exciting uterine action. Of course the tampon had a tendency to also induce the latter effect. That there had been two recurrences of the accidental hemorrhage was an interesting feature of this case.

Dr. H. K. Pusey reported a case of cerebral congestion wherein the patient manifested decided suicidal and homicidal tendencies. He was a railroad man who had suffered from insomnia for a year or two. On reading the newspaper account of the Brownfield tragedy in this city, he was seized with an impulse to kill his wife, his child, and himself. So far he has been able to control himself, but about twice a month he is harassed with these insane impulses. The treatment has been by bromides, with an occasional dose of hyoscine hydrobromate.

Dr. McDermott questioned the sincerity of the patient.

Dr. Pusey said that this need not be doubted, since, while in the state described, the patient's pulse ranged from 90 to 108, while the pupils were habitually contracted and the eyes unsteady.

Dr. Cecil asked if the incarceration of a man in his condition should not be insisted upon.

Dr. Pusey said that the man at times was unquestionably insane, but he did not believe that a jury could be induced to consider him so. A patient, whose case he had studied at the Central Kentucky Insane Asylum, had had a similar history, which terminated in permanent insanity.

Dr. Dabney asked if the pupils of the patient (whose case was first reported) failed to respond to light during the attacks of cerebral congestion.

Answered in the affirmative.

S. G. DABNEY, M. D.,

Secretary.

## Reviews and Bibliography.

**The Medical Bulletin Visiting List, or Physician's Call Record.** Arranged upon an Original and Convenient Monthly and Weekly Plan for the Daily Recording of Professional Visits. Net prices are, No. 1, Regular size, to accommodate 70 patients Monthly or Weekly, \$1.25; No. 2, Large size, to accommodate 105 patients Monthly or Weekly, \$1.50. Philadelphia: F. A. Davis.

The plan, scope, and uses of this novel list are well set forth in the following, which we take from the publisher's advertisement:

"This visiting list is arranged upon a plan adapted to the most convenient use of all physicians, and embraces a new feature in recording daily visits not found in any other list. The necessity of rewriting the names of patients every week is obviated, as the arrangement of half-pages requires the transfer of names only once a month; at the same time the record is kept just as perfect and complete in every detail of visit, charge, credit, etc., as by the old method. From this it will readily be seen that a large amount of valuable time is saved, as well as a great deal of labor formerly necessitated in rewriting the patients' names.

"This visiting list contains a calendar for the last six months of 1888, all of 1889 and 1890; Table of Signs to be used in keeping Accounts; Table of Fees; Dr. Ely's Obstetrical Table; Tables for calculating the number of doses in a given R., etc.; for converting Apothecaries' Weights and Measures into Grams; Metrical Avoirdupois and Apothecaries' Weights; Number of Drops in a Fluidram; Graduated Doses for Children; Graduated Table for Administering Laudanum; Periods of Eruption of the Teeth; The Average Frequency of the Pulse at different ages in Health; Formulæ and Doses of Hypodermic Medication; Use of the Hypodermic Syringe; Formulæ and Doses of Medicines for Inhalation; Formulæ for Suppositories for the Rectum; The use of the Thermometer in Disease; Poisons and their Antidotes; Treatment of Asphyxia; Anti-emetic Remedies; Nasal Douches; Eye-Washes."

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**Therapeutics Founded Upon Organopathy and Antipraxy.** By WM. SHARP, M. D., F. R. S. 203 pp. London: George Bell & Son. 1888.

This is intended as a substitute for the doctrines of Hahnemann. Instead of like curing like, the author believes he has discovered that the opposite is true in so far as that small doses of any given medicine act in a way opposite to that of larger doses. So that, if a disease is such as might be produced by a large dose of a given drug, a small dose of the same drug would cure it. Likewise the poisonous effect of a drug given in large doses would be off-set by a small dose given subsequently.

That there is much in the teaching and practice of many in the medical profession who walk by faith to try the patience of those who are not willing to see science hopelessly bemuddled by the needs of art is only too true. But with the fair and just teaching of such men as Flint, Bristowe, Niemeyer, Strümpell, and others, one need not be driven to a monomaniac mysticism to escape the absurd outcome of such fallacious reasoning or no reasoning. Dr. Sharp shows more than the average of acumen and much earnestness, but we doubt if he does not close his earthly labors without a convert. In fact the psychological phenomena presented by the author's mind present claims for study that surpasses those of his labored theory.

D. T. S.

**A Manual of Dietetics for Physicians, Mothers, and Nurses.** By W. B. PRITCHARD, M. D., New York City. 88 pp.; price, 50 cents. Published by the Dietetic Publishing Company, New York.

Commencing with the toilet for the child in the lying-in-room, Dr. Pritchard here attempts to give a suitable diet for patients suffering with nearly every form or stage of disease. The fault of the work is that there is not enough of generalizing. The man who goes into details of the diet for measles, small-pox, scarlet fever, and a half dozen other diseases where the fever requirements are the same, has given us three and a half dozen times as much to remember as there is any need of. The book that is in these days

of literary surfeit entitled to be read, is the book that presents principles and right generalizations. The tendency of the author appears to be also to exaggerate the value of artificial food, so much so, indeed, that we might be led to suspect that the book is an ingenious advertisement for some of these articles.

D. T. S.

**Theine in the Treatment of Neuralgia.** By THOMAS J. MAYS, M. D., of Philadelphia. 84 pp.; price, 50 cents. Philadelphia: P. Blakiston, Son & Co. 1888.

This small volume relates the experience of the author in the use of theine in the treatment of several painful affections, among them neuralgia, sciatica, muscular rheumatism, and even the pains of locomotor ataxia. If even a small part of the author's experience should be generally verified, it would still be a valuable contribution to the practice of medicine that might allow the use of morphine to be in some measure dispensed with.

D. T. S.

**The Prescription: Therapeutically, Pharmaceutically, and Grammatically Considered.** By OTTO WALL, M. D., Ph. G., of St. Louis. 184 pp.; price, \$1.50. St. Louis: Published by the Aug. Gast. Bank Note and Lithographing Company. 1888.

An excellently written work containing much useful and much curious information; but the verdict can hardly fail to be that there is too much of it. However, for the physician who has never studied Latin and who has given no attention to pharmacy, we can recommend the work as a useful and profitable companion.

D. T. S.

## Correspondence.

### PARIS LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Dr. Du Moulin has lately published, in the *Lyon Medical*, a note on the treatment of pneumonia. The author considers that the gravity and the danger of this affection exist in the intensity of the fever at the commencement, in the extent of the inflamma-

tion, whence the circulation and the respiration are profoundly affected. The right side of the heart exhausts itself in struggling against the pulmonary obstacle, while the carbonic acid, in consequence of the insufficient respiration, accumulates in the blood. Du Moulin admits as the principal indication, that of aiding the heart in its struggle. It must be enabled to push vigorously the blood through the pulmonary vessels which have remained permeable, and thus permit the circulation to maintain itself until the termination by resolution of the pneumonic processes. The heart is sustained, at the commencement, with a moderate dose of digitalis; when once the pulse is slackened, the digitalis should be replaced by alcohol, under the form of port wine. Against the hyperthermia, high doses of quinine (one gram in general) and large blisters, Dr. Du Moulin does not consider that the fever here would contra-indicate blisters; on the contrary, they are equally useful against the pain in the side, the intense dyspnea, the the pulmonary edema at the outset. In confirmed pulmonary edema the author adds to the large blisters repeated doses of wine, camphor, and, if there is no diarrhea, he administers calomel and jalap in small doses, as follows: Calomel, ten centigrams, jalap, one gram, in ten powders, one every hour. The nervous and adynamic symptoms are treated by the hypodermic injections of the oil of camphor (ten centigrams of camphor for injection), and should there be the least suspicion of alcoholism, chloral should be administered at a hypnotic dose, but very moderately, in the evening about nine o'clock. The defervescence once obtained, the general state insured against syncope, resolution is favored by small doses of alkaline drinks.

In connection with this subject I may give the summary of a note read recently by Dr. Petresco, of Bucharest, before the Academy of Medicine of Paris, entitled: "The treatment of Pneumonia by High Doses of Digitalis." The author stated that pneumonia, distinctly inflammatory or frigore, is one of the most frequent maladies in the

Roumanian army. During the last five years, as principal physician to the Military Hospital of Bucharest, he had to treat more than six hundred pneumonic patients, from twenty-one to twenty-five years of age. The experimental researches and the clinical observations of the learned physician, who is also professor of therapeutics, have led him to the following conclusions: (1) Pneumonia may be aborted ("jugulated") by digitalis in strong doses, administered at the commencement of the malady. (2) This abortive treatment is the most rational, as it is based on the pathogenic indication of pneumonia. (3) The efficacy of this treatment is confirmed by statistics; the lowest rate of mortality is observed in the pneumonias treated by high doses of digitalis. (4) The dose of from four to eight grams per day of the leaves of digitalis in infusion, which the author prefers to any other preparation, constitutes the veritable therapeutic dose against the pneumonia of adults, and he adds, that at this dose only have we a right to expect immediate salutary effects. (5) The tolerance and the non-toxicity of this therapeutic dose are proved in an incontestable manner by nearly six hundred clinical observations, which had been very carefully collected and already published.

It is generally supposed, even by members of the profession, that the brown cod-liver oil is more active than the colorless oil, but, according to MM. Gautier and Mourgues, the reverse is the case, which they announced at a recent meeting of the Academy of Sciences, in a work describing the results of their researches to determine the alkaloids of cod-liver oil. They analyzed both the brown and colorless cod-liver oil, and alkaloids have been found in the latter, which is recognized as the most active. The bases, subjected to fractional distillation in a bath of oil, separate into two groups (almost equal in weight) of volatile and fixed bases. The bases are as follows: Morrhaine, butylamine, amylamine, hexylamine, hydrolutidine, aselline. Besides these six alkaloids, the authors found an acid, to which they have given the name of morrhucic acid, which is

important on account of its relative abundance, its double function of acid and of alkali, and by its origin, which is very probably connected with the existence of vegetable lecithines. This acid is found in the form of an unstable and complex combination, behaving as do the ordinary lecithines, that is to say, it soon gets altered, particularly if it is heated in the presence of acids and alkalis, in setting free glycerine, phosphoric acid, and a complex acid. The authors think that the lecithines contribute to the beneficial action of this medicament in presenting phosphorus to the economy under a form eminently assimilable. Morrhucic acid is of a resinous aspect, but capable of crystallizing into flattened square prisms. It dissolves in alcohol, and very little in ether. It is remarkable by its double aptitude to combine with the bases and acids, and gives crystallized chloroplatinates. MM. Gautier and Mourgues found that the brown oil contains notable proportions of ptomaines, whereas they discovered infinitesimal traces in the oils extracted from fresh livers. This is another reason why the pale oil should be preferred.

Dr. Augagneur, of Lyons, writes, in the *Province Médicale*, a note, giving the result of his treatment of certain cutaneous affections by the internal use of carbolic acid. He thinks that this therapeutic agent does not act here as an antiseptic and antiparasitic, and its mode of action remains still unknown and completely inexplicable. This medication is quite easily borne on the condition that the quantities employed do not exceed one gram for adults and fifty centigrams for children. The average dose per day for children is from thirty to sixty centigrams, and that for adults is from fifty centigrams to one gram. In these doses the carbolic acid may be absorbed during weeks and months without producing the least accident, nor the black color of the urine so characteristic of intoxication with carbolic acid. The success of this medication is constant in the prurigo of children, and in prurigoes in general. Eczema is ameliorated in the dry and lichenoid forms,

more rarely in the acute and humid forms. Psoriasis is never influenced by this medication. The author concludes his note with the statement that several of his patients had been treated by other medications, and none had given results so prompt, so distinct, and so durable as that in question.

PARIS, Dec. 21, 1888.

## Abstracts and Selections.

REPORT ON DISEASES OF CHILDREN: THE CEREBRAL PALSIES OF CHILDREN.—Osler has reviewed the clinical material at the Philadelphia Infirmary for Nervous Diseases, and at the Pennsylvania Institution for Feeble-minded Children at Elwyn. Three divisions were made: hemiplegia, one hundred and twenty cases; bilateral hemiplegia, nineteen cases, and paraplegia, eleven cases.

*Hemiplegia* is a common affection in children, according to some writers occurring as frequently as spinal paralysis, but at the Philadelphia Infirmary for Nervous Diseases, the proportion is not quite one to four. Of the one hundred and twenty cases, five were boys and sixty-three girls. There was right hemiplegia in sixty-eight and left in fifty-two cases. Of one hundred and ten cases at which the age at the onset was noted, fifteen were congenital, and in eighty-one the disease came on within the first three years of life. In nine cases the children were delivered with forceps; three were due to trauma; sixteen followed the infectious diseases. In the majority of cases the disease begins with convulsions and the hemiplegia is noticed when the child recovers consciousness. Incomplete recovery is the rule, but the patients are liable to the serious sequences of epilepsy and mental disorders. Thirty-one cases presented post-hemiplegic movements. The result of an analysis of ninety autopsies is given. In sixteen instances there were vascular lesions, as plugging of a sylvian artery in seven, and hemorrhage in nine.

The age of onset in this group was high, as, excluding three congenital cases, there was only one under three years of age. Atrophy and sclerosis were met with in fifty cases. Two instances are recorded of sclerosis from the Elwyn institution.

*Bilateral spastic hemiplegia* is characterized by a spastic condition dating from, or shortly succeeding birth. There is no wasting; the

reflexes are increased, the mental condition profoundly disturbed and ataxic, and athetoid movements of the most exaggerated kind may occur. Nineteen cases are described; two of bilateral athetosis. In sixteen autopsies that have been reported the condition has been either cortical sclerosis or parencephalus.

*Spastic paraplegia* in children is closely related to bilateral hemiplegia, but the arms are not affected. It dates from birth, or comes on within the first years of life. The legs are stiff, the heels raised, and there is strong adductor spasm. The patient walks on the toes or there is cross-legged progression. The intellect is not so profoundly impaired as in bilateral hemiplegia. Eleven cases are described.

The morbid anatomy of the affection is not yet clear. Only one autopsy (by Förster, from the Dresden Children's Hospital) is reported. Cerebral lesion with descending degeneration was present. The reasons are given for believing that it is of cerebral origin, as suggested by Heine many years ago, when he named the disease "*paraplegia cerebialis spastica*." In the discussion on the pathology of the cerebral palsies, apoplexia neonatorum is held to play an important part in the production of bilateral hemiplegia and paraplegia. In hemiplegia there is still much doubt as to the nature of the initial lesion. Strümpell's polienccephalitis has not yet been demonstrated anatomically, though the view is very plausible, and subsequent autopsies may show the truth of it. The relation of the cases to the infectious diseases may be due to embolic processes associated with endocarditis, to arteritis or peri-arteritis such as has been described in the heart in typhoid fever, or to changes in the cerebral gray matter, similar to those which have been described in the cord in measles by Barlow.

The conclusion is reached that infantile hemiplegia is the result of a variety of different processes, of which the most important are:

1. Hemorrhage, occurring during violent convulsions, or during paroxysm of whooping-cough.
2. Post-febrile processes: (a) embolic; (b) endo- and peri-arterial changes; (c) encephalitis.
3. Thrombosis of the cerebral veins.

Under the section on treatment the question of operative interference is discussed, and two cases are noted in which trephining was performed for Jacksonian epilepsy following infantile hemiplegia.

These are held not to be suitable cases for operation.

*Acetonuria.* Baginsky has demonstrated the presence of acetone in the urine of healthy children, thus showing the existence of a physiological acetonuria for children, as has already been done for adults. He found that, pathologically, acetonuria stands in the closest relationship to the duration and intensity of the pyrexial condition; and experimentally, too, he found that in dogs acetonuria is intimately connected with protein waste.

*The Influence of Bacteria upon the Digestion of Children.* Baginsky, in a paper before the Berlin Medical Society, states that the bacterium of the lactic fermentation causes the production of acetic acid and acetone, as well as lactic acid. This formation goes on without oxygen, and is not hindered by the bile.

The neutral lactates are changed to butyric acid; starch is not changed to sugar, nor is casein or albumen decomposed. The gases formed when acetic acid is produced are carbonic acid, hydrogen, and methane.

He proposes to name this bacterium the "acetic bacterium." He further found that this bacterium is destroyed by acetic acid.

In examining the stools of children suffering from cholera infantum, he isolated a bacterium which produced green stools (the germ of Hayem and Lesage), and also a bacterium growing in white colonies. Both of these liquefy gelatine, and both are inhibited in their development by the acetic bacterium; this germ has the property of preventing the growth of pathogenic germs in the intestine.

Baginsky considers that only the primary manifestations of cholera infantum are caused by bacteria, and that the secondary, severer phases result from the extensive anatomical lesions which have occurred in the intestine. It is evident that the treatment of a given case will depend upon the stage of the disease. He found that calomel, boric acid, and resorcin prevent the growth of the acetic bacteria; naphthaline and iodoform are inert. If the case is seen early, when acetic fermentation is excessive, these remedies and the withdrawal of milk are indicated. If pathogenic bacteria have accumulated in the stomach or intestines, irrigation with antiseptic fluids is advised. Each case must be studied separately, and interference with the conservative processes, as shown in the inhibitory action of certain bacteria, should only be undertaken intelligently.—

*Dr. T. M. Rotch, Boston Medical and Surgical Journal.*

THE VALUE OF "HYSTERORRHAPHY" IN THE TREATMENT OF RETROFLEXIONS OF THE WOMB.—The name "hysterorrhaphy"—which literally signifies only suturing the uterus—has been given by my friend, Dr. Howard A. Kelly, of Philadelphia, to the process of sewing a displaced uterus to the anterior wall of the abdomen. Dr. Kelly, whose enthusiasm in gynecology and whose operative skill is equaled only by his modesty, did me the favor to discuss with me this proposal on several occasions before putting his views in print. In the *American Journal of Obstetrics* for January, 1887, will be found an interesting article from his pen, in which he condenses the brief history of the operation up to that date, quotes most of the few recorded cases and discusses the rationale and technique of the procedure.

For all interested in the subject of hysterorrhaphy, this paper of Dr. Kelly must remain an important landmark for a long time to come. I have freely used the substance of it in what I now have to say.

For ten years or more efforts have occasionally been made to fasten a displaced uterus to the abdominal wall as a supplement to laparotomy performed for other purposes.

Thus in February, 1880, Mr. Lawson Tait (*Dis. of Ovaries*, Am. ed., pp. 94 and 95) narrates a case of ovaritis, complicated by persistent retroflexion, in which, "after removing the appendages, and while closing the wound," he "passed a stitch through the fundus uteri and fastened it up to the abdominal wall."

In another similar case of chronic interstitial ovaritis, complicated by fundal metritis and retroversion, he repeated the same expedient of April 9th of the same year. Both cases recovered, and in both the uterus remained *in situ*.

In 1885 Koeberlé published, in Billroth and Lücke's *Handbuch der Frauenkrankheiten* (Bd. I, 767, Stuttgart, 1885), the report of a case in which, in 1877, he had removed the uterine appendages; and, raising the womb from Douglas' pouch, had sewed the stumps of the appendages into the abdominal incision with good effect.

Kelly's first operation was done in 1886, upon a patient who had undergone two previous laparotomies during the two preceding years. Here, after removing a right hydro-salpinx, he ligated the right *cornu* of the uterus at two points a half centimeter apart, "and between the two passed two silk sutures down through the uterine tissue and up into the abdominal wall," tied them, and thus fastened "the displaced uterus in ante-position about four centimeters above the pubis to the left of the incision." (*Loc. cit.*, p. 35.)

Similarly Dr. T. Gaillard Thomas writes me, that for seven or eight years he has been occasionally in the habit of securing the womb to the abdominal wall as an adjunct to removal of the appendages, etc. Dr. Boldt and Dr. Coe have also operated, the first of these repeatedly, in this city. But, so far as I know, the first person to urge hysterorrhaphy as a primary operation, that is, as a laparotomy for the sole purpose of securing in anteversion an intractably displaced uterus, was Professor Olshausen, of Halle, who, in the fifty-ninth meeting of the Gynecological Section of the German Naturalist's Society, held at Berlin, in September, 1886, read an important paper on Laparotomy for Prolapsus and Retroversion of the Womb (*Ueber Ventrale Operation bei Prolapsus und Retroversio Uteri*), in which he narrated two apposite cases, and so strongly urged its trial as to induce Säger, of Leipsic, and other German operators to imitate his practice.

One of Olshausen's operations was for retroflexion with adhesions, one for excessive prolapse; both had resisted all other kinds of treatment. The first succeeded, the second failed, but the principle of the new operation and its feasibility were clearly demonstrated, and it remained for experience alone to prove what its utility might be.

In passing the suture from the *cornu uteri* to the abdominal wall, Olshausen thought much danger menaced the deep epigastric artery; this I have not found to be the case. He preferred silk-worm gut as more reliable than cat-gut, and as least likely to prove an irritant, but proposed to use thick silver wire in future. He advises several sutures to affix the uterus to the abdominal wall, passing them either through the *cornu uteri* or through the broad ligament in such way as to cause them to encircle the round ligament. If the patient be past the menopause, the fallopian tube may also be included in the enveloping knot; otherwise it is to be carefully avoided.

In the *Centralblatt für Gynäkologie*, No. 2 et seq., for 1887, Säger, of Leipsic, discusses this subject with much thoroughness and force. This paper is termed the Operative Treatment of Retroversio-flexio Uteri, in which mainly the "direct" method of dealing with this lesion is considered. Under this designation are included:

1. Von Rebenau's method of resecting the anterior wall of the cervix.

2. Alexander's operation of shortening the round ligaments.

3. Laparotomy, followed by ventral fixation of the uterus.

The latter is the special object of the paper. Seven personal cases are narrated, five of

which were what I term "secondary," that is, cases in which the fixation was supplemental to ovariectomy or castration; and two were "primary," or cases in which the sole object of the laparotomy was the hysterorrhaphy.

This process or "ventral fixation," as Säger calls it, is thought the only direct operative means by which the uterus can be maintained anteverted; and he strongly urges it, by Olshausen's method, "as a secondary step to every laparotomy for removal of the diseased appendages where the uterus, whether adherent or not, lies retroflexed." In primary cases he deems the severity of the symptoms the only index of its justifiability.

In comparison with it the Alexander operation is condemned; and still more strongly Klotz's method of partial hysterorrhaphy, aided by a supporting glass drainage-tube behind the uterus, is criticised and rejected.

I have thus far performed hysterorrhaphy as a *primary operation* six times, with four results so good as to be commonly called cures, one failure, and one as yet undecided.

As to the *justifiability* and proper *indications* of hysterorrhaphy as an elective operation, I have only this to say:

1. Ten or fifteen years ago, as laparotomy then was practiced, hysterorrhaphy would have been indefensible. At the present day this can not be said. If sometimes difficult of performance, it is certainly less dangerous than extirpation of the appendages or of any morbid growth, while the suffering it aims at relieving is often quite as great.

It is incontestable that cases occur in practice where retroflexion of the womb, with fixation, causes untold suffering and finally ruins the patient's health; where pessaries can not be borne, and would do no good if they could; and where it is absurd to remove the appendages, for they are quite healthy. In such cases hysterorrhaphy finds its proper field; and, unless the uterine massage of Dr. Th. Brandt, of Stockholm, be found to supplant it, the operation must remain a necessity. Of the value of massage so applied I am incompetent to speak, and, in spite of the interest it has lately excited in Northern Europe, I have felt skeptical as to its claims.

2. Of the relative value of hysterorrhaphy and the Alquié-Alexander operation, I think it useless to speak; for, in spite of the comparisons instituted by Dr. Kelly and Prof. Säger in the papers quoted, they seem to me to be essentially distinct and irrelevant.

The most necessary condition of cases suitable for Alexander's operation, is that the womb should be movable and non-adherent, otherwise no traction upon the round ligaments could

dislodge it. *Per contra*, if there be no adhesions or fixation, even the most enterprising laparotomist would hesitate to advise a primary hysterorrhaphy.

The cases suitable for it, therefore, must be necessarily limited; they are those in which fixation of the womb from adhesions exists in a malposition, and which resist other milder modes of treatment.

The technique of the operation has been so fully described by Olshausen, Kelly, and Sanger, that it needs no repetition here. I shall only say, in conclusion, that, after a number of experiments, I think the sutures should *not* be passed through the fundus uteri, which is often excessively vascular and bleeds like a sponge, but through the proximal end or edge of the broad ligament so as to encircle the round ligament; and above not only through the parietal peritoneum, but through the supra-peritoneal fat.

And while silk-worm gut answers well, if previously soaked in hot water to make it flexible, the very best suture material we as yet possess is Chinese fine twisted silk, rendered carefully aseptic before use.

Catgut of any strength or quality is inadmissible from its liability to be rapidly absorbed, and silver wire of any size is much more likely to tear the broad ligament than to act kindly. In applying the suture, the aim should always be to have it remain permanently and become encysted. While separating adhesions the fingers only should be used, and those about the distal ends of the broad ligaments torn through first. Then, as the uterus is drawn up toward the abdominal wall, one can better distinguish the utero-sacral ligaments from dense adhesions in the bottom of the pelvis. Serious and very intractable hemorrhage may come of neglecting this distinction.

The operation is only to be done with all antiseptic precautions, and its subsequent treatment is like that of every laparotomy.

Thus far no death from hysterorrhaphy has been recorded.—*Dr. Charles Carroll, American Journal of Obstetrics.*

**EXTRA-UTERINE PREGNANCY.**—At a recent meeting of the Philadelphia Obstetric Society, Dr. Theophilus Parvin exhibited a specimen of a fetus removed by Mr. Tait in the latter part of August. Pregnancy was supposed to have advanced six or seven weeks. The patient was doing well when he last heard of her condition—four days after the operation. He thought that Mr. Tait was really the most wonderfully expert abdominal surgeon he had ever seen. In

his work no antiseptics are used; perfect cleansing of the hands with soap water, brush, and towel; perfect cleansing of the abdomen; incision through the skin and underlying tissues; hemostatic forceps used if necessary, but frequently not required; the use of forceps to take up the tissues as the peritoneum is approached; the raising up of the peritoneum almost an inch, so that there is no risk of injuring any thing beneath the membrane; incision into the peritoneum; the moment the incision is made the introduction of one or two fingers, or rather the index finger and the thumb. In this case the diagnosis was not positive, only probable, before opening the abdomen; but as soon as he had introduced his fingers into the abdominal cavity, he said that it was a case of extra uterine pregnancy with rupture of the tube. It took probably five minutes to bring up the ruptured cyst and ligate the tube with the Staffordshire knot. After removing the tube and ovary, water was poured in through a funnel to which was attached a rubber tube with a nozzle. The metal nozzle was pushed around in all parts of the abdomen so as to wash out all of the clots. In this particular case two pitcherfuls of water were used. A drainage-tube was introduced, and three stitches closed the abdominal incision. This patient did not have a temperature above 100°, and when seen three days later her recovery seemed almost absolutely certain.—*American Journal of Obstetrics.*

**EPIDEMIC DIPHtheria.**—Nearly four years ago an epidemic of diphtheria made its appearance in a town in Cape Colony, where I was resident. Very few families escaped the disease, and those who did were, I believe, the possessors of filters, and accustomed to pay some attention to hygiene. There had been no case of diphtheria in the place for at least three years, and certainly no similar epidemic during an antecedent period of ten years. The only cause we could assign for the sudden outbreak was the pollution of the main water stream, which flowed unprotected through the streets in an open furrow. For two or three weeks prior to the first appearance of the disease exceptionally heavy rains had fallen, washing out every exposed privy and kraal, and carrying filth accumulations (in some instances of years) straight into the stream. All the inhabitants were dependent upon this one source for their supply of water. One farmer came to town with his children, and, when about to return, he took

a sufficiency of water from the contaminated stream for the homeward journey, a drive of fifteen miles. The three children drank of the water, and within ten days all of them developed diphtheria, of which one died.

Two years ago, when in practice in the Midlands, I was summoned in great haste to see a child aged two years. The patient was moribund, and presented most marked laryngeal and other diphtheritic symptoms. Death took place soon after my visit. The only other child of this family, four years of age, was "ailing," the mother said. Her tonsils presented characteristic patches and the *malaise* of diphtheria. Inquiry elicited that the stable adjoining the house had been but recently "cleaned out," at which process both these children had been present, and had been allowed to play in the stable for an hour or two afterward. — *Dr. John Irving, British Medical Journal.*

**TREATMENT OF RHEUMATIC TETANUS.**—*Dr. Arnstein*, of Ratibor, mentions in the current number of the *Therapeutische Monatschrift* a case of rheumatic tetanus occurring in a boy seven years old, who three days after getting wet through suffered from fever and rigidity of several groups of muscles. During the first fortnight the temperature varied from 38.5° to 39° C., and tetanic contractions of the maxillary muscles and also of those of the abdomen and back occurred. Chloral and morphia were given frequently and in large doses, but in spite of this the patient's sleep was very restless and disturbed by numerous attacks of muscular spasm. During the second week an infusion of hyoscyamus, belladonna, and conium, as recommended by *Dr. Meldon*, of Dublin, was given, and immediately produced a marked effect, the attacks becoming less frequent and less severe. At the beginning of the third week the child contracted scarlet fever from his sisters; but this did not interfere with the improvement in the tetanic condition. He was convalescent in about six weeks.—*London Lancet.*

**ADDISON'S DISEASE.**—Additional support is given to the doctrine that the group of symptoms accompanying Addison's disease rests largely upon the involvement of the abdominal sympathetic in the chronic inflammatory process, in an article by *Dr. von Kahlden*, of the Pathological Institute, University of Freiburg. (*Virchow's Archiv*, Bd. cxiv, Heft. 1.) He describes two cases: one in which both capsules were character-

istically degenerated, and the other in which the right capsule alone contained caseous masses. In both, it may be remarked, tubercle bacilli were found in the caseated material. In the first case the right semilunar ganglion exhibited "pigmented atrophy" of the ganglion cells, considerable hyaline degeneration and thickening of the walls of many of the blood-vessels, small-celled infiltration of the adventitia, and more or less circumscribed foci of round cells near the vessels; while the nerves entering the ganglion, as well as the splanchnic nerve, showed no change beyond slight thickening of the perineurium. In the right ganglion there was similar pigmented atrophy of cells, and marked thickening of vessel walls leading to narrowing and even occlusion; but the hyaline changes and the round-celled infiltration observed in the left ganglion were not present. In the second case he observed in the right ganglion (corresponding to the diseased capsule) thickening of the cell capsules, scattered peripheral hemorrhages, and relics of previous hemorrhages, occlusion of vessels and thickening of their walls by connective tissue; and in the left ganglion a considerable number of recent hemorrhages in the periphery, and a certain amount of thickening around the ganglion cells. Although these anatomical changes suggest the implication of the ganglia as being an essential feature of Addison's disease, *Dr. von Kahlden* admits that they do not suffice to attribute to such lesions the cause of the affection. His paper contains a summary of a large number of cases in which some lesions of the ganglia have been noted, and also others where these structures were declared to be normal; but he thinks a much larger number of carefully recorded facts are necessary before the suggested conclusion is reached. He holds that the few cases yet recorded where the capsules were found to be intact, and where the ganglia were involved in other pathological processes, are too incomplete to be of service in determining the point; but he does not mention some of the more recent instances on record of Addison's disease apart from the characteristic change in the capsules. It is curious to note in how few cases the tubercle bacillus has been detected in the diseased capsules, but the positive discovery by *Guttman*, *Rauschenbach*, *Goldblum*, and now by *von Kahlden*, must be weighed against the frequent negative results of the search for it, especially considering the sparseness of its distribution in these caseated organs. The association with

tubercular disease in other parts of the body is too frequent to permit us to ignore the probability of the suprarenal affection being tubercular. The paper also contains a study of the pigmentation of the skin characterizing Addison's disease, in which the author shows that the pigment is deposited in the deeper layers of the rete and in the outer zone of epithelium of the hair follicles. He finds the pigment not formed in the cells themselves, but deposited in the cutis and transferred thence by leucocytes, one epithelial cell taking up pigment from several leucocytes. In all probability the pigment is derived directly from the blood; not because of any morbid condition of vessel-wall, or on account of hemorrhages, for such are not constant, and when present are obviously secondary. Lastly, he thinks that a careful observation of the pigmentation of mucous membranes in future cases may throw further light on the relation of the pigment to the blood-coloring matter.—*Ibid.*

**AN IMMENSE DUODENAL ULCER.**—Drs. Ivar Svensson and C. Wallis report the following interesting case of "Duodenal ulcer, causing obliteration of the common bile duct, the hepatic duct, the cystic duct, and the canal of Wirsung." The patient was a man of forty-three, who had been taken ill ten months previously with symptoms which indicated a complete obstruction of the flow of bile into the duodenum. He had lost strength and flesh to such an extent that it was thought advisable to re-establish the flow by an operation. Accordingly a communication was made between the base of the distended gall-bladder and the small intestine. The patient died a few days after the operation. At the necropsy an ulcer was found in the duodenum, exactly in the position of the common bile duct and the canal of Wirsung, the hard fibrous tissue which formed its base having obliterated these channels. The inflammatory material had extended so far that the cystic duct was altogether closed. The hepatic duct, the canal of Wirsung, and the gall-bladder were all very much distended. The necropsy also showed that the end for which the operation had been performed had not been attained.—*Ibid.*

**EARLY SIGNS OF PREGNANCY.**—There are probably very few physicians who have not at times felt the need for some trustworthy means of deciding upon the existence or absence of pregnancy at a time when if present it could not be far advanced, and when it is too soon to ex-

pect to hear the sounds of the fetal heart or to obtain the confirmation of *ballotement*. In this country Hegar's sign of pregnancy, which has been well described by Dr. A. K. Bond, in an article in the Maryland Medical Journal, in the early part of this year, has not received the attention it deserves, and American physicians have failed to appreciate, or at least to practice, Hegar's method.

This sign is to be determined by combined rectal and abdominal examination. It consists in the detection of an unusual softness, thinning, and yielding condition of the lower uterine segment—that is, of the part immediately above the insertion of the sacro-uterine ligaments. This condition of the part is perceptible whether the rest of the body of the uterus feels firm and hard, or soft and elastic. Even in the latter case it is always possible to compress the lower uterine segment, to draw it out to a certain degree with the fingers, and so to distinguish it from the part above it; while below, the cylindrical cervix of firmer consistence is felt distinctly coming off from it. The yielding and flaccid condition of the part may be so great that one may doubt whether there is any connection at all between the neck and the larger swelling in the abdomen or pelvis. This is especially true when pregnancy occurs in a uterus with hypertrophic elongation of the cervix; and even laparotomy has been done under the mistaken idea that the pregnant corpus was a tumor independent of the uterus. The condition referred to depends upon the fact that the lower uterine segment, as the thinnest part of the corpus, on account of pregnancy, becomes succulent, of looser texture, thinned, and extremely elastic. According to Reine, "failure to find this, however, in no way excludes pregnancy, since it is easy to see that with marked chronic infarctio uteri (hyperplasia) pregnancy may exist without rendering this condition of the lower uterine segment very evident."

There is another useful sign of pregnancy which depends upon the well-known fact that, in the first eight weeks of pregnancy, the principal enlargement of the uterus is in the antero-posterior diameter of its corpus, while the cervix undergoes scarcely any change, except a superficial softening at the external os. The direction of the enlargement of the body of the uterus causes it to project markedly from the cervix, especially in front. The shape of the whole uterus has been likened by Grandin to an old-fashioned fat-bellied jug. This striking relation between the corpus and cervix is readily distinguished by one moderately skillful in making the bimanual examination. A quite characteristic boggy, soft-

ening, and compressibility of the lower uterine segment is also detected. This sensation is brought about by the effects of physiological congestion of pregnancy upon the uterine tissues, and partly, also, by the fluid contents of the uterus.

The condition just described is an almost positive sign of pregnancy, especially if in addition there is marked fullness and pulsation of the vessels on both sides of the pelvis, without evidence of pelvic inflammation, and a more or less distinct purple hue of the vagina. It is reliable as early as the sixth or eighth week.

It would seem, theoretically, that this method of examination had one marked advantage over combined rectal and abdominal examination, for not only can the physical condition of the lower uterine segment and increased mobility of the corpus be made out nearly as well, but the striking jutting out of the corpus over the cervix is much greater in front than behind, and therefore more easily detected through the vagina than through the rectum. Naturally the employment of both methods of examination would give more trustworthy information than either alone. This condition of the lower uterine segment was apparently known to Dr. Rosch as long ago as 1873, but he failed to appreciate fully the subject and only laid stress on the feeling of fluctuation to be obtained by bimanual examination.—*Medical and Surgical Reporter*.

**MENSTRUATION AFTER ENTIRE REMOVAL OF BOTH OVARIES.**—An unmarried woman, aged twenty-four, was, in the beginning of this year, placed under my care by Dr. Pollock. On February 3d I performed ovariectomy, and finding the other ovary also diseased, removed it likewise. The patient had neither pain nor fever; indeed, she recovered with less difficulty than often follows a quite trivial injury, leaving my immediate care in three weeks and going into the country. The interest of the case centers, however, on the events subsequent to the entire removal of both ovaries. At the operation I took away on the left side the whole of the cystic ovary, together with the greater part of the fallopian tube and pampiniform plexus, which were spread out upon the cyst wall. On the right side the ovary was nearly double its normal size, very hard and fibrous; it was much altered in form, being almost kidney shaped, with the long axis directed obliquely upward and inward; the ligament being attached to what would represent the hilus. This ligament and the vessels were tied and severed quite three

quarters of an inch inside the gland. I am quite certain, as also is Mr. Sheild, who most kindly and ably assisted me, that not the minutest part of the ovary was left behind. Menstruation remained absent, although in April she complained of "flushings" and pain in the back until the middle of June, when a very slight catamenial discharge appeared. A month later, and every month since, she has menstruated regularly, "just as she used to do before the operation."—*Dr. Richard Barwell, London Lancet*.

**VICARIOUS MENSTRUATION.**—Cases of vicarious menstruation, clearly marked, are so rare that I should like to put on record the following:

In January, 1888, my advice was asked about Miss E. F. by her mother. The young lady was fourteen years old, and had always been well. She was not at all nervous, read no novels, and spent much time out-doors, riding, or otherwise sensibly occupied. She was not a "bleeder," and not subject to nose-bleed. In the preceding June the first menstrual flow took place, lasted one week, and was normal in every respect. Four weeks later, however, the menses did not appear, but for three or four days there were one to three profuse nose-bleeds daily. There was also a slight headache (congestive?). The statement was volunteered that the blood seemed to irritate or excoriate the nose somewhat. This monthly epistaxis continued up to the time of my knowledge of the case, in January. It did not seem to me, however, that any but expectant treatment was justifiable, the general health being so perfect. It remains to say that after these nose-bleeds had recurred with perfect regularity for fourteen months, the catamenia began, scanty at first, and the epistaxis diminished. And at seventeen months from the first menstruation, the function had become normal, and so remains.

I have imperfect notes of a second case, seen at the Massachusetts General Hospital. The girl, C. McD., aged thirteen, was brought by her mother, who told me that about Christmas, 1887, the headache of which the girl had complained became worse, and for two or three days she spit up blood. The same symptoms recurred in January. In February she had a severe nose-bleed for one hour. In March she had nose-bleed two or three times. I did not feel certain about the interval between these occurrences, nor indeed of the accuracy of the statements made me; but I did not think there was any in-

tention to deceive. This report was in March, 1888. A few months later the catamenia had appeared for the first time and become normally established, and the epistaxis and spitting of blood had ceased.—*Dr. H. F. Vickery, Boston Medical and Surgical Journal.*

**EPISTAXIS DEPENDENT UPON THE INFLUENCE OF THE GENITAL APPARATUS.**—(*Joal, Rev Mens. des Mal. de l'Enf.*, June, 1888.) Recent authors, especially Zuckerkandl and Kiesselbach, have described, in place of the varicose venous plexuses of the nasal mucous membrane which used to be recognized as such, a true erectile tissue, or *corpus cavernosum*, which is situated immediately under the epithelium of the nasal membrane. In certain individuals this erectile tissue has a great tendency to become turgescient, and even to be the seat of hemorrhages under the influence of direct irritation or of psychical impulses. Epistaxis of the latter variety is very apt to be confounded with the so called essential hemorrhage which is of such frequent occurrence at the period of puberty, and upon the development of which the influence of the genital apparatus has a decided bearing, in the author's opinion. He insists upon the physiological relations which have long been admitted to exist between the nose and the genital organs. These relations have been demonstrated by John Mackenzie, Ischwall, and Arviset, and have been confirmed by numerous curious phenomena which have been observed by Van der Wiell, Elsberg, Tilly, and Moure, among which may be mentioned the attacks of sneezing which are excited in some individuals by sexual intercourse, and sneezing, weeping, and dyspnea which have been reported in the case of an asthmatic individual under the same circumstances.

Pituitary phenomena attributable to the same cause have also been observed in certain women at the time of their monthly periods, these phenomena consisting in obstruction of the nose, with profuse nasal discharges, and sneezing, and in addition cough, migraine, asthma, swelling and redness of the skin of the nose, and vertigo, all of which point to turgescence of erectile tissue. The author has successfully treated with the thermo-cautery a patient affected with stoppage of the nostrils, periodic frontal neuralgia, sneezing, and an abundant nasal secretion, which was sometimes accompanied with nausea and vomiting. All nasal affections, including coryza, seem to be influenced by morbid conditions of the genital organs, and may be relieved by suitable treatment of the latter. Attention is also called to the chronic nasal catarrh, with purulent discharge and

perversion of the sense of smell, which sometimes affects persistent masturbators. The nose-bleed which is so common in young girls at the time that menstruation is established is cited as a further proof of the interdependence of the genital apparatus with the nasal mucous membrane. Cases are also narrated in which young girls who masturbated suffered from nose-bleed after indulgence in the vice.—*Archives of Pediatrics.*

**AMPUTATION DURING THE PRESENCE OF ACUTE PHLEGMONOUS ERYSIPELAS.**—*Mr. W. H. T. Winter* brings forward a case of amputation of the toe during the presence of erysipelas. The following, I think, will be of interest as bearing on that point.

On July 13th of this year I removed the middle finger of Mrs. B., aged seventy-seven, for old-standing disease. The wound did not do well, and on July 16th there was well-marked cutaneous erysipelas spreading up the fore-arm. This increased, and by the 19th there was great swelling and edema of the fore-arm, extending also to above the elbow; there was evidence of disintegration of the wrist-joint from pus formation. As the fever was great and the agony of the pain severe, and it was evident the disease would soon prove fatal to a person of her age, it was decided to remove the hand at the wrist joint; this was done. After the hand was removed, a quantity of pus was able to be squeezed downward to the cut surface by pressure with the hand. The patient, notwithstanding her advanced age, and the fact that there was much albumen in the urine, made an excellent recovery, and that rapidly. There was a swelling on the anterior aspect of the elbow-joint for a fortnight afterward, but it disappeared without trouble. Four days after the operation the patient was able to sit in an arm-chair and partake of fish for dinner.—*Dr. A. H. Croucher, London Lancet.*

**ANTEPARTUM GANGRENE OF THE LOWER EXTREMITIES.**—I am induced to report this case for the reason that I am convinced that it must be extremely rare, and, besides, it well illustrates how impossible it sometimes is to make a correct diagnosis.

I was called on October 5th to see a woman, aged about forty years, now the mother of three children, the last three confinements having been premature. She was a fat, swarthy individual, and averred that she was seven months pregnant and was sure she was in labor. Her last three deliveries were still-births; but this time, she said, she had "felt life" till two weeks previously, and even that day had been

conscious of distinct movement. Both she and her husband were anxious to know if she were about to have a living child, as they had an impression that her health would be much benefited by nursing one. I first listened for the fetal heart sounds, but owing to the depth of abdominal fat and her restless state it was difficult to make a very satisfactory examination. However, I was quite certain that I detected the feeble beat of the fetal heart, and accordingly assured the parents that their wish would be gratified with the birth of a living child; but imagine my disappointment and chagrin, after so confidently giving the parents such positive assurance, when, on making a vaginal examination, I found a breech presentation, with a peculiar feel, without natural warmth, and the skin peeling off on slight rubbing. I said nothing until I had brought a foot down and found it dead from the toes upward. Then I had to admit that I was mistaken, and that the child was not only lifeless, but badly decomposed. With a sharp pain the infant was projected into the world, when, to my amazement, it commenced to cry with all the vigor of any full-time normal offspring. Here, indeed, was quite an anomalous state of affairs: a baby born, partly dead and partly alive. The upper extremities and body were quite natural and healthy looking; but from the hip downward the lower extremities were thoroughly gangrenous. The infant lived about twenty-four hours, and the mother made a good recovery.—*Dr. T. H. E. Manley, Ibid.*

**NEW OPERATION IN EMPYEMA.**—Professor M. S. Subbotin, of Kharkoff, describes in the *Vrach* (No. 45) a new operation he has devised for opening the thoracic cavity in empyema, with the view of obviating the danger arising in Estlander's operation and in the modifications of it practiced by Schede and Sprengel from the extensive raw surface which is necessarily allowed to remain in contact with the purulent discharge. Professor Subbotin suggests that in cases where the lung itself is free from disease, the unyielding nature of the thoracic wall may be overcome without the removal of ribs by simply cutting them through; also that if a rib is divided in two places and the intermediate portion removed, the chest wall will become flexible and may be pressed inward so as to lessen the cavity of the empyema, and in this way assist to put an end to the suppuration. After thinking out a plan based on the above considerations, he determined to apply it in operating on a case under his care in the Kharkoff clinical wards last June. The patient having been chloroformed, an incision was made along the seventh rib,

which was then stripped of its periosteum and excised to the extent of seven or eight centimeters. An extensive opening was here made into the pleural cavity. After the pus had been evacuated the cavity was carefully cleansed and the opening well covered with gauze, and a gauze compress applied. An incision was then made along the border of pectoralis major about five centimeters in length, exposing the sixth, fifth, and fourth ribs, and these were cut away (the periosteum not being left) with forceps until the rib became movable. Another incision was then made in the line of the posterior fold of the axilla, exposing the same ribs, which were again divided before; the wounds were then sutured and dressed with gauze, a large thick pad of the same substance being applied outside, with a good compress bandage round the thorax. The upper wounds were kept from communication with the empyema. When after a few days the intra-thoracic wound was dressed, a drainage-tube was put in. The case recovered, but three months after the operation there was still a small sinus which continued to discharge. The advantages claimed by Professor Subbotin for his operation are, the small raw surface which is left in contact with the purulent matter, and the firm but movable portion of thoracic wall which can be pressed inward by bandaging so as to diminish to a considerable extent the size of the cavity.—*Ibid.*

**SUBDURAL ABSCESS OF THE BRAIN.**—The following are the conclusions of Sir William Stokes regarding abscess of the brain:

1. That after the primary symptoms of cerebral traumatism have subsided, there is frequently a latent period of varying length, during which there are no distinct brain symptoms connected with abscess formation whatever.

2. That their appearance is, as a rule, sudden, and if uninterfered with they run a rapidly fatal course.

3. That the concurrence of pus production resulting from cerebral traumatism is not incompatible with a perfectly apyrexial condition.

4. That the latter fact will probably aid in differentiating traumatic cerebral abscess from meningeal or encephalic inflammation.

5. That both as regards color and consistence there is great variety in the contents of cerebral abscess cavities, and that, as shown in Wilne's case, published by Rose, of Berlin, they may become transparent.

6. That antisepticism has largely diminished the risks of the operation of trephining.

7. That, having regard to the great mortality of cases of cerebral abscess when uninterfered with, viz., from ninety to one hundred per cent, the operation is indicated even when the patient is *in extremis*.

8. That, in the case when the trephine opening does not correspond to the situation of the abscess, exploratory puncture and aspiration may be employed.

9. That by the adoption of this measure the necessity for multiple trephine openings can be largely obviated.

10. That the employment of a blunt-pointed aspirating needle, as suggested by Rentz, is probably the safest mode of exploration and evacuation.

11. That drainage is desirable in the after-treatment of such cases.

12. That both during and subsequent to operative interference in these cases a rigid antisepticism is imperatively required.—*Polymer*.

**WOUNDS OF THE HEART.**—Dr. S. Thomas, of Rotterdam, relates two cases of wounds of the heart, which are of some interest. The first is that of a girl who was stabbed by her lover in a fit of jealousy with an ordinary household knife. After receiving the wound she got up from her seat and ran into another room, where she dropped and died in five minutes, having gone a distance of about eight yards from the spot where she was stabbed. The necropsy showed that the knife had passed in a slanting direction from the upper border of the second right costal cartilage through the sternum at the junction of the manubrium with the corpus sterni, through the right auricle, behind the pulmonary artery, and finally through the aorta. The pericardium was full of blood, the heart firmly contracted and empty; and it was the pressure of this effused blood, unable to escape, that caused the heart to stop beating. Very little hemorrhage had taken place externally, but the right pleural cavity was filled with blood. The main points of interest in this case, Dr. Thomas thinks, are the ease with which the knife penetrated the sternum, "like going through butter," and the distance the girl ran after the injury. The other case was that of a laborer, who was stabbed with a sheath-knife by one of his fellow workmen, whom he was annoying. The knife entered at a spot seven centimeters to the left of the sternum, between the third and fourth ribs. It pierced the anterior edge of the lung and the pericardium, and made a great gaping wound in the left ventricle. The pericardium was full of blood, the heart not contracted, and the left pleural cavity so full of blood that

the lung was collapsed. In this case death followed almost immediately after the injury. Dr. Thomas ascribes this suddenness to the fact "that so much blood emptied itself in so short a time through the great gaping ventricular wound that the further duration of life was impossible."—*London Lancet*.

**THE RELATIONS OF LUPUS VULGARIS TO TUBERCULOSIS.**—(Bender, *f. Arch. Kinderh.* iv. 4. 5.) From a pathologico-anatomical and etiological standpoint it is not yet accepted that lupus vulgaris is a tuberculous process, but in a clinical sense the two processes are quite similar, and the great mass of literature upon the subject seems to encourage the idea of their resemblance, if not their identity. The author's views are based upon the study of one hundred and fifty-nine cases, in ninety-nine of which he found tuberculous or scrofulous or other elements which were attributable to the influence of the tubercle bacillus. In twenty additional cases there was a history of previous tubercular lesion or of inherited tendency to tubercle. Among the opponents of the relationship of tubercle and lupus may be mentioned Kaposi, but the theories of this and other writers upon the subject can hardly be said to be convincing when compared with the positive results of clinical investigations such as are furnished by the author of this paper.—*Archives of Pediatrics*.

**THE SPREAD OF TUBERCULOSIS.**—At a meeting of the Society of Medical Jurisprudence and State Medicine, held November 8th, Dr. G. J. Johnson read a paper on tuberculosis in animals, in which he expressed the conviction that nearly all human tuberculosis was caused by eating the flesh of animals or poultry, or drinking the milk of cows affected with the disease. While it was almost impossible to estimate the prevalence of animal tuberculosis, he believed that in a considerable percentage of all cattle the bacilli of the disease existed, and that the danger of putting upon the market the meat or milk from affected animals could not be overestimated.

To substantiate his position, Dr. Johnson stated that in the few countries where no cattle exist a case of tuberculosis has never been known among the inhabitants; and hence he claimed that if tuberculous cattle could be exterminated consumption would die out among men. In furtherance of this end he thought that the government should pay farmers liberally for killing all their affected cattle. The germs of the disease are no doubt spread to a large extent by the habit which is so common among the animals of

licking each others' noses, the excessive discharge at the nostrils incident to the disease being filled with the bacilli.

In Europe this matter has already received considerable attention on the part of the authorities, and in Belgium the government had gone so far as to order that any calf from which vaccine virus is taken shall be killed and a *post-mortem* search made for tuberculosis, in order that by no possibility may the disease be conveyed to those vaccinated.

In the discussion which followed the reading of the paper, Dr. E. F. Brush, who has made a special study of bovine tuberculosis, agreed substantially with the views of Dr. Johnson, but thought the danger from eating meat or drinking milk infected with its germs was not quite as great as represented by the latter.—*Boston Medical and Surgical Journal*.

**THE BACILLUS OF DIPHTHERIA.**—D'Espine, of Geneva, has made a series of researches confirmatory of Löffler's claim that a certain bacillus discovered by him in diphtheritic false membranes is the causal agent of diphtheria. The results are published in the *Lyon Médical*. D'Espine has never failed to find Löffler's bacillus in cases of true diphtheria or diphtheritic croup; and he has in many instances succeeded in reproducing the disease in hares and guinea-pigs by inoculating the products of a series of pure cultures; bacilli from a twenty-fifth culture were proved to have the same pathogenic properties, and speedily induced the disease. *Ibid*.

**FREQUENCY OF DISEASE OF THE MIDDLE EAR.**—Dr. V. P. Zerenin, of Moscow, has published an account of an extensive series of examinations he has made on the condition of the middle ear in still-born children and in children who have died before they were weaned. He finds that it is best to begin the examination from the tympanic membrane, as this is usually sufficiently transparent to permit the nature of the contents of the cavity to be seen before it is destroyed. One result obtained, which is important from a medico-legal point of view, was that a portion of the liquid in which an animal was drowned, or in which the body of a child was immersed, was capable of finding its way to the middle ear. Some four hundred bodies of children dying in the Moscow Foundling Hospital were examined, of which details are tabulated in two hundred and forty-five cases. Out of this number, it is somewhat astonishing to learn that the tympanic cavity was found to be normal in thirty only. In

twenty the middle ear contained air, and, in addition, a bloody, mucous, or puriform liquid. In fifty-seven cases dark gray mucus or mucopurulent matter was found, with tumefaction of the mucous membrane. No less than one hundred and thirty-eight cases presented the signs of purulent catarrh. The frequent occurrence of suppuration of the middle ear is accounted for by Dr. Zerenin by the fact that the children had been brought up under bad hygienic conditions, besides being insufficiently nourished, their ears thus forming suitable soil for the development of piogenic microbes. He suggests that more attention should be paid to ear diseases in infants, and points out that constant restlessness, especially of the legs, is very frequently an indication that disease of the middle ear is commencing.—*London Lancet*.

**A CASE OF AKROMEGLIA.**—At a recent meeting of the N. Y. County Medical Association, Dr. Adler (Boston Medical and Surgical Journal, November 22, 1888) exhibited a case of this rare disease, which was first described and named in 1886, and which has never before been observed in this country. The patient, a German woman of thirty-four, was first seen eight months before. Her family was healthy. She had been strong and well until her eighteenth or twentieth year, the time of the onset of the disease not being clearly remembered. Menses began when she was fifteen, were always irregular, and ceased entirely after three years. When she was about twenty, she noticed that her feet would swell at times, the swelling yielding to a shoe or bandage. There was swelling of submaxillary and other glands about the same time. Was married at twenty. At twenty-three her finger enlarged so that her wedding ring had to be cut off. Her chief trouble was pain in the back, weakness, and migraine. Being unable to walk, she lay generally in a semi-recumbent position. At first sight one would be impressed by the great size of the head and the marked projection of the lower jaw, and would naturally suspect myxedema or a condition resulting from extirpation of the thyroid gland. The tongue was hypertrophied and flabby. The teeth were good but somewhat separated from one another. The hair was abundant. All the lymphatics of the neck were enlarged. The right lobe of the thyroid gland was wanting. There was no trace of the thymus gland. There was great enlargement of the clavicles and ribs, with consequent bulging of the chest. The adipose tissue of the body was not increased. The bones of the limbs were all enlarged, and the same was true of the pelvic bones. The finger-nails were normal. The

feet and hands were immensely enlarged. The muscles were everywhere flabby and atrophied. The skin was greatly thickened, but for the most part soft and pliant. In the parts which were hypertrophied there was marked hyperesthesia. Ophthalmoscopic examination revealed nothing abnormal. The urine was normal. The blood exhibited upon microscopic examination the appearance of perfect health, although the patient seemed anemic. Appetite was good, bowels slightly costive, heart and lungs and other organs normal. The electric excitability was diminished, but, probably not from degeneration of the nerves. The patient had been bright and lively as a girl, but was now dull and apathetic, exhibiting marked psychical degeneration.

Dr. Adler, after reviewing briefly the very unsatisfactory pathological theories advanced to explain the symptoms of this disease, went on to speak of the treatment, which consisted simply in rest, diet, regulation of the bowels, and the administration of antipyrine which controlled the migraine.—*Maryland Medical Journal*.

**VOCAL MUSIC AND PREVENTION OF PHTHISIS.** At the meeting of the Medical Society of Virginia, October 23, 1888, Dr. C. E. Busey, of Lynchburg, Va., read a paper on the cultivation of vocal music in public schools as one of the means of preventing phthisis. He states it as a well-known fact that those nations which are given to the cultivation of vocal music are strong, vigorous races, with broad expansive chests. If an hour a day in public schools were devoted to the development of vocal music, there would not be the sad spectacle of the drooping, withered, hollow-chested, round-shouldered children which confronts us now. There is too great a tendency to sacrifice physical health upon the altar of learning. Vocal music is gymnastic exercise of the lungs, producing increased expansion of the lung tissue itself. The lungs in improved breeds of cattle, which naturally take little exercise and are domiciled much of the time, are considerably reduced in size when compared with those animals running at liberty; and so it is with the human beings who lead inactive lives. Phthisis generally begins at the apices of the lungs, because these parts are more inactive, and because the bronchial tubes are so arranged that they carry the inspired air with greater facility to the bases than to the apices. During inactivity a person will ordinarily breathe about 480 cubic inches of air per minute. If he will walk at the rate of six (six) miles an hour, he will breathe

3,260 cubic inches. In singing, this increases more than in walking, as singing well requires all of the capacity of the lungs. The instructor of vocal music, in addition to his musical education, should understand the anatomy and physiology of the respiratory organs.—*Virginia Medical Monthly*.

**PROGNOSIS IN NEURASTHENIA.** Dr. Landon Carter Gray states with regard to the prognosis in neurasthenia that it is variable in each of the forms. The purely reflex form will end in recovery, as a rule, when the reflected cause is removed. The lithemic form will vary in prognosis according to the severity of the nervous symptoms and the time of the year when the first symptoms show themselves. If the nervous symptoms are slight, the recovery is usually speedy. If the nervous symptoms are severe, and especially if the vertigo is marked, the duration of the disease may be prolonged through a year, even with treatment, and the vertigo may last several years. Relapses are not infrequent. Warm weather, he says, has a markedly unfavorable influence upon the nervous symptoms—so much so that he has never known severe nervous symptoms, beginning in the spring or early summer, to disappear until cold weather made its appearance. The simple form of neurasthenia, he states, has usually an excellent prognosis if radical treatment is adopted; otherwise recovery is a matter of chance, and he has known cases which he believed to be of this form pass into a gradual and fatal exhaustion. Dr. Webber states that marked disturbance of the arterial tension is of evil prognosis, and *vice versa*; but Dr. Gray has not as yet been able to test this point himself.—*N. Y. Medical Journal*.

**BACTERIOLOGY OF SNOW.**—While the bacteriology of ice and hailstones has been studied with considerable success by Drs. Frankel, Bischoff, Mitchell, Prudden, Pumpley, Hills, Stoben, A. V. Poehl, Bordone-Ufreduzzi, Bujwid, etc., that of snow has been, up to the present, almost wholly neglected. Even in Russia the subject has been touched only in a cursory way by Professor A. V. Poehl in a paper on the water-supply of St. Petersburg, in the *Vratch*, Nos. 8 and 9, 1884, page 119. In it he points out: (1) That snow always contains viable microbes, liquefying gelatine; (2) that, when snow falls, the first portions invariably contain greater numbers of bacteria than the subsequent ones (for example, 8,324 per 1 cubic centimeter of snow-water against 3,380 sev-

eral hours later); (3) that, when snow lies on the ground, the superficial layers become richer in microbes (for example, 780 just after the fall, against 962 about three hours later). The fact is of interest from a sanitary point of view, as Dr. Poehl's researches furnish an additional proof that exposure of microbes to low temperatures does not destroy their vitality, at least, in certain species of micro-organisms. In many countries, such as Russia or Sweden, snow forms, so to speak, a natural ground or soil during several months of the year, receiving excrementitious matter, and every possible kind of refuse and filth. In spring, when the snow melts, it is imbibed by the soil, carrying with it all the polluting matters referred to. Hence an interesting question arises, Are such microbes as happen to be present in these matters in any way changed by their contact with snow or not? This point can be determined only by further bacterioscopic researches. A contribution to the subject has just been published in the *Vratch*, No. 37, 1888, page 727, by Dr. F. G. Ianovsky, of Kiev, who has examined bacterioscopically, under Professor K. G. Tritshel's guidance, a February snow in its purest state, collected both immediately and from one to three days after its fall. This observer has found: (1) That even when collected during its fall, snow is invariably found to contain living bacteria in considerable numbers, varying from 34 to 463 per 1 cubic centimeter of snow-water; (2) that their number does not decrease from exposure of snow to low temperatures ( $-16^{\circ}\text{C}.$ ) for several days; (3) that the following three species of microbes are met with constantly in great numbers, (a) a large diplococcus composed of ovoid cocci, endowed with energetic motion, and characterized by its rapidly liquefying jelly; the test-tube culture on the third day, forming greenish colonies along the track of the needle, assumes the shape of a funnel-like sac with a whitish flocculent deposit, while on the fifth the whole medium becomes liquefied, the precipitate sinking to the bottom; on agar a pale grayish-white streak is formed at the site of inoculation on potato or fairly thick white film; (b) small-sized cocci often arranged two and two, energetically mobile, and slowly growing on jelly without liquefying the medium, the growth proceeding solely along the track of the needle in the shape of a narrow stripe consisting of non-coalescing minute points of a yellow color, while on the surface the colony is seen as a grayish-white, circular, slightly prominent patch with somewhat fringed

edges; on agar the coccus forms a white streak with sinuous edges, on potato a gray film with a brownish tint; (c) very large cocci liquefying jelly as late as three weeks after inoculation, and growing along the track of the needle in the form of a sharply defined streak of a beautiful pink color, with a slightly elevated pink circular patch or "cap" on the surface; on agar the microbe forms a freely-spreading white film with a rosy tint, on potato a thick, tallow-like pink coat with sharply defined fringed contours; (4) that the first two species (a and b) are also met with commonly in the water of the river Dnieper, which flows through the town (*vide* Dr. Ianovsky's bacterioscopic examination of the water, published in the *Meditsinskoië Obozrenië*, Nos. 9 and 10, 1888, page 975), while the peculiar pink micrococcus seems to occur only in snow; (5) that, generally speaking, the microbes liquefying jelly in falling or recently fallen snow are met with invariably in far greater numbers than in snow which has been on the ground for some time; this, in fact, very often contains only such bacteria as do not liquefy gelatine; (6) that the bacteria of snow originate partly from aqueous vapors which are transformed into snow, partly and chiefly from the air, that is, they are carried away by the snow-flakes on their passage through the atmosphere. — *British Medical Journal*.

**PASTES IN DERMATOLOGY.**—Since Lassar introduced into dermatological practice the use of salicylic paste, the utility of pastes in irritable conditions of the skin has been abundantly proved. Dr. Gruendler, of Hamburg, has recently made some interesting experiments in Dr. Unna's laboratory on the relative capacity for the absorption of water inherent in various powders which might be used in the preparation of these pastes. He found that carbonate of magnesia had remarkable qualities in absorbing water, and therefore ought to be an excellent ingredient for the formation of a paste. Unfortunately, however, pastes made of a mixture of fat and carbonate of magnesia do not possess the proper consistence. When, therefore, this highly absorbent quality of carbonate of magnesia is desired, it is advisable to combine it with the other powders commonly used. For example, fifty parts of oxide of zinc or starch may be mixed with ten parts of carbonate of magnesia, and the whole rubbed up with fifty parts of fat to form a paste, or as a simple absorbent powder it may be very conveniently used mixed with oxide of zinc.—*Ibid*.

# The American Practitioner and News

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## IS THE PRACTICE OF MEDICINE A FAILURE?

The New York Medical Record of the 15th ult. presents its readers with a characteristic leading article upon this vexed question. The editor holds the inquiry to have a two-fold significance, discussing it in its relation to the physician and in its relation to the public.

The counts made against the success of the practice of medicine under the first head are, that a large majority of those who enter upon this calling fail to make a living, and so drop out of the ranks; that these failures are, in a degree, out of proportion to the failures in other pursuits requiring equal time and expenditure of capital; that the wear and tear of professional work are excessive in proportion to the pecuniary, intellectual, and moral returns; that the limit of life of medical men is lower than that of most other professional classes, and that, admitting a fair proportion do gain a livelihood and a few attain some degree of honor and pecuniary reward, medical men, with few exceptions, die poor.

Under the second head, he says: "We exclude, of course, surgery and hygiene, and assume only that the question, 'Is medicine

a failure?' relates to the application of drugs and other remedial measures to actual disease. We have lessened the number of infective and septic disorders; but when they attack an individual are they any more perfectly under control?" Referring to the recent discussion which seems to prove that pneumonia is to-day more fatal than it was a half century ago, he allows that "the mortality from diphtheria, scarlet fever, typhoid, and phthisis is somewhat lower than it used to be, and that a vigorous defense of modern therapeutics might be made in connection with these and other common diseases," but holds that the question must be answered with reference to society in general rather than to the individual. For "though we pull many weakly patients through attacks of illness by aid of modern therapeutics, is not the result an increase of invalidism which tends to propagate itself, producing in succeeding generations an oversickly race?"

Though the counts under the first arraignment are in a measure true, and offer little if any encouragement to him who would enter the profession of medicine with no nobler motive than lust for wealth or fame, they are insignificant in the eyes of him who looks upon the guild as a priesthood, and sees in his calling only an opportunity to devote his life to the good of man. Those under the second, however, are more serious, and, if true, would keep out of general medicine all worthy men, relegating its practice to quacks with and without diplomas.

To leave surgery and hygiene out of the discussion is simply to beg the question, since outside of and to a great extent in the great cities all practitioners are surgeons and hygienists as well as physicians.

We shall not attempt the "vigorous defense of modern therapeutics in connection with diphtheria, scarlet fever, typhoid, phthisis, and a number of other common diseases," which the editor suggests might be made, since we believe he is competent to make such defense more vigorously than we, and since his admission that it might be made is sufficient to show that, after all, the prac-

tice of medicine is not altogether a failure in his critical eye. Moreover, if we were called to descant upon the therapeutic efficiency of drugs in the treatment of certain diseases, we should prefer to leave scarlet fever, typhoid, and phthisis off the list.

The last count is the statement of a truth which can not be lightly set aside. For while it is true that under the skillful ministrations of the physician many patients are pulled through attacks of illness who in after-life show no impairment of health, it can not be denied that in many more his efforts are opposed to the order of nature and promote the survival of the unfit. That this "result is an increase of invalidism which tends to propagate itself, producing in succeeding generations an oversickly race," there can be no doubt. But the arraignment (if we had allowed his exclusion of surgery) would strike the surgeon quite as heavily as the physician. Viewed from this altitude, which compels us to lose sight of the individual in contemplation of the race, the physician and surgeon shrink into dwarfish proportions, while the hygienist stands out colossus-like in bold relief.

But, until we return to the primitive simplicity of the savage who abandons the weak, the aged, and the sickly to the mercy of the elements or wild beasts, or rise to the utilitarian altitude of the ancient Greek who cast all bantlings on the rocks that seemed not fit to survive, the practice of medicine will be counted no failure so long as it results in the lessening of suffering in the individual and in the saving of life, be the issue a help or a hindrance to the higher evolution of the race.

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#### A NEW ANTIPYRETIC.

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It seems that the materia medica is about to be further encumbered by yet another synthetical compound of antipyretic properties. The new chemical is called *pyrodine*—not to be confounded with *pyridin*; it is a white crystalline powder, very sparingly soluble

in water, and almost tasteless. Dr. R. Wild has investigated its physiological properties in the laboratory of Owen's College, and Dr. Dreschfeld, of Manchester, England, has put it to the therapeutic test in numerous persons suffering with various diseases. In the hands of the latter it has proved to be far more potent to reduce fever and produce destructive blood changes than antipyrin, acetanilide, phenacetin, or any other compound of the same class.

In doses of eight to twelve grains, given on consecutive days, the drug produced no effects, ill or otherwise, on persons in health. In such as had diseases characterized by fever, however, the temperature was very markedly reduced by three doses in from two to four hours, while in some diseases, notably typhoid fever and rheumatism, toxic symptoms of an alarming character were observed. These were such as characterize the doings of an overdose of aniline, namely, jaundice, the appearance of aniline in the urine, and such disturbances of the circulatory and respiratory functions as characterize destructive blood changes. In view of these effects the observers warn the profession against the indiscriminate use of the drug in the following language: "*Pyrodine should never be given in a larger dose than twelve grains, and this only once in eighteen or twenty-four hours. It is not safe to continue its use for more than a few days. If either of these precautions is neglected, serious, or even fatal symptoms may be rapidly induced.*" A study of the drug with reference to analgesic influence seems not to have been made; but doubtless it, like others of its class, has power to lessen or abolish pain in certain cases. We have passed in review the record of the performances of pyrodine, that our readers may take timely warning and so fight shy of it when it shall land on our shores under a flourish of trumpets blown by some foreign manufacturer.

The practice of reducing fever by means of certain synthetical alkaloids is a questionable therapeutic measure at best, which has been abandoned by many of our best practitioners. If there be any good in the practice, the drugs now in use are sufficient

for the desired end, and certainly these are potent enough for harm to the patient and discredit to the doctor when administered in fevers of the asthenic type. It is therefore to be hoped that the profession of this country will turn a cold shoulder to the new poison, no matter how warmly its claims to favor may be advocated by those who hope to profit by its manufacture and sale.

### Notes and Queries.

**THE WASTE AND SUPPLY OF MEDICAL PRACTITIONERS.**—A statement of the number of students who last month commenced their special studies in the various metropolitan and provincial medical schools of England was published in the *Journal* for October 20th. From the numbers there given, it would appear that 668 students have entered for the full medical curriculum, being about 40 above the average of the previous five years, though 15 less than the number of such entries in October, 1887.

To any one who considers these figures, certain questions present themselves: What is likely to become of these young men? What sort of careers will they probably pursue; and what amount of success may they be expected to achieve? As to the ultimate careers of individual students, it is of course impossible to speak beforehand with any precision, but as to the aggregate welfare in life of the 668 one may already predict with tolerable certainty the proportion of failures and successes which is in store for them. The classical paper on the subject, published by Sir James Paget in the *St. Bartholomew's Hospital Reports* for 1869, supplies data which may be used for the inquiry. Of 1,000 of his pupils whose after-careers were known to him, Sir James Paget found that (a) 23 (2.3 per cent) had in fifteen years achieved distinguished success; (b) 66 (6.6 per cent) had achieved considerable success; (c) 507 (50.7 per cent) had achieved fair success; (d) 124 (12.4 per cent) had had very limited success; (e) 56 (5.6 per cent) had failed entirely; (f) 96

(9.6 per cent) had left the profession; (g) 87 (8.7 per cent) had died within twelve years of commencing practice; and (h) 41 (4.1 per cent) had died during pupilage.

Lately, too, the Dean of St. Mary's Hospital School, Mr. G. P. Field, has occupied himself by tracing the careers of students educated at his school. He found that 1 000 men had joined the hospital up to last May, of whom 284 are present students, so that 716 had to be accounted for in other ways. Of these 716, 17 had left the profession, and 171 had been lost sight of altogether, some probably having also left the profession, and others having doubtless died. In addition to these, 64 were known to be dead, and 12 had failed entirely. These numbers (17, 171, 64, 12) added together amounted to 264, and left 453 (63.2 per cent) in practice. Of the 453, 371 were in general practice (231 in the country, 99 in London, 31 abroad, while 10 were dentists), 48 were in the army and navy, and 34 had achieved the great success of being on hospital staffs as teachers, or were distinguished in various other ways (14 had been elected on the staff of St. Mary's Hospital, 9 were on the staffs of other hospitals, and 11 others were distinguished men). Thus, according to Mr. Field's figures, about 34 of 716 students, or less than 5 per cent, achieved distinguished success. Sir J. Paget's figures give only 2.3 per cent for the same class; but then he seems to have limited himself to fifteen years of practice, whereas Mr. Field's observations in some cases must have extended over thirty years, which may account for the difference, as distinguished success comes to some men only after tedious waiting.

Of Sir James Paget's 1,000 students, 720 (72 per cent) were apparently in practice, while Mr. Field makes those of his 716 students as thus engaged 63.2 per cent. These figures of the two observers at the oldest and youngest medical schools of London respectively coincide sufficiently to make it tolerably certain that about 470 of the 668 students who have just entered will eventually engage in practice. It at once,

therefore, occurs to one to inquire if the number of students now yearly pressing into the profession is more than the number required to fill up vacancies caused by death and to provide for the wants of the growing population of these islands. So far as England is concerned the query may be decidedly answered in the affirmative by reference to the figures published in a report issued last spring by the Statistical Committee of the General Medical Council, which gives the information enabling one to speak with certainty as to the distribution of medical practitioners. Reference thereto shows that, during the five years from 1881 to 1886, there was in England and Wales a net increase in the profession of 826 members beyond what was requisite to keep pace with the population; that is, an annual excess of no less than 165; and as the number of students now entering the profession (from Scotch and Irish as well as English schools) shows no appreciable diminution, there is little hope that the recent rate of "overstocking" will be sensibly lessened within the next few years.—*British Medical Journal*.

*Editors American Practitioner and News:*

At the December meeting of the Hardin County Medical Society the following preamble and resolutions were passed on the demise of Dr. G. W. Whitehead, of Vine Grove, Ky:

*Whereas* (in His Providence), Almighty God has seen fit to remove from our midst our worthy and much-esteemed brother, Dr. G. W. Whitehead, of Vine Grove, Ky., therefore be it

*Resolved*, by the Hardin County Medical Society, that we deeply deplore his untimely death, and miss his wise counsel in our Society; and that each of us imitate his virtues as exemplified in his daily walk.

*Resolved*, That we tender to his bereaved relatives our heartfelt sympathy in this their hour of sore affliction.

The deceased was uniformly kind and pleasant in his intercourse with his professional brethren, and true and faithful to his

*clientele*. In him the poor ever found a friend and helper in time of need.

It might be said he died in harness, as he continued his work days after he really should have been in bed.

He died of typhoid fever, at the age of thirty-one years, in the prime of early manhood, and in the midst of a promising career. In his death his neighbors and friends sustain almost an irreparable loss, and the profession lose an able and gentlemanly *confrère*. He leaves a wife and child to mourn his decease.

*Be it further resolved*, That this notice be published in the Elizabethtown papers, and also in the Practitioner and News, and that a copy be sent to his bereaved family.

T. B. GREENLEY,  
J. T. SELBY,  
*Committee.*

PROFESSOR VON BERGMANN ON VON LANGENBECK.—The lately-published volume of the Transactions of the German Congress of Surgery, held at Berlin in April last, contains the full text of Professor von Bergmann's admirable address in memory of the late Professor von Langenbeck. In that address he sketched the career of the great surgeon, who, as he said, did not belong to the discoverers and thinkers who have advanced our ideas in surgery, but whose fame rests upon the work he did for surgery in Germany, giving it a special stamp and direction. Contemporary with the great monarch whose loss they were then deploring, Langenbeck did for German surgery what Kaiser Wilhelm accomplished for the nation, and his influence would endure. For when he began life the surgeons of Germany stood far behind those of France and England; they did not originate, but simply availed themselves of the work done in other lands. That they now "take more than equal rank" with their Western neighbors is largely owing to Langenbeck. Until the first decade of this century there had been no German names which could equal those of Paré, Petit, Desault, Dupuytren, Cheselden, Pott, Cooper, or John Hunter; and even Dieffenbach gained his experience in

France, and made his first important contribution on plastic surgery to a Paris society. The first independent German school of surgery was founded by Von Kern in Vienna, the second by Langenbeck in Berlin. Langenbeck introduced the scientific element, owing doubtless to his early attachment to science, for his career opened as a *privat-docent* in physiology and pathological anatomy. Professor von Bergmann attributes considerable influence in determining Langenbeck's future course to a visit which he paid to England, where he became acquainted with Brodie, Lawrence, Henry Green, and Astley Cooper. He was struck with our hospital wards and with our Royal Medical and Chirurgical Society, which he subsequently took as a pattern for similar societies in his own country. This visit was also the occasion of the formation of a good understanding between German and English surgeons—a relationship evidenced in later years in the nomination of Paget, Lister, and Spencer Wells in the honorary Fellowship of the Berlin Surgical Society, which Langenbeck founded. He always retained a cordial friendship with his English *confrères*, and was warmly welcomed on the occasion of his last visit in 1881, when the International Congress was held in London. Professor von Bergmann tells how Langenbeck, on his return from England in 1840, met Stromeyer at Erlangen, and how he definitely adopted surgery as his profession, being a few years afterward appointed to Kiel. He shows how his influence in the improvement of surgery was especially marked in three directions. The first was the cultivation of physiological science in its application to surgery. From his school have come many and important contributions on the histology of tumors, the development of bone, and regeneration of tissues; while some among his pupils—as Billroth and Heuter—have done much to pursue bacteriological studies and explain infective processes. Another new departure made by Langenbeck was in the extension of the field of operative interference. His own work upon the surgery of bones and

joints, especially subperiosteal resections, was largely based upon the results of experiment; and the same is true of the wider and bolder extension to operations upon the larynx, the kidneys, intestines, stomach, and brain, in the furtherance of which his pupils have had a fair share of the credit due to the pioneer. Lastly, he reformed and reorganized military surgery. Some of his earliest experiences (1848-49) were in the battle-fields of Denmark, and it was during this troubled time that he was nominated to the Berlin chair in succession to Dieffenbach. He was Consulting Surgeon-General in the Danish war of 1864, and served again in 1870-71. To him is mainly owing the high state of perfection to which the care for the sick and wounded has been carried in the German army. But we must refer our readers to the address itself if they wish to read a worthy record of a noble life. Professor von Bergmann, who occupies the position vacated by von Langenbeck, was peculiarly fitted to deliver this address, which gives so clear an idea of what Germany's great surgeon was as a professor and as a man. In comparing the place formerly occupied by Germany in surgery to that it now holds, he could not, perhaps, have avoided the expression of pride at her present position in the van of scientific surgery; but he would be the last, we feel sure, to disparage the progress made in other countries. It is pleasant to find in the *éloge* a record of Langenbeck's love and admiration of British surgery, which we trust will be transmitted to his successors.—*London Lancet*.

CAUSES OF DEPOPULATION IN FRANCE.—Among the causes of the depopulation of France, referred to in my letter of last week, I may mention the enormous mortality among nurslings. According to a report recently laid before the Chamber of Deputies, one hundred and fifty thousand is the number of infants dying annually in France from improper or premature feeding and misery. While the number of births does not attain nine hundred thousand, the number of deaths that occur in the first year after

birth is, on an average, two hundred and thirty thousand, including forty-five thousand still-born. In this last figure are not comprised miscarriages or abortions. The author of the report remarked that the evil seems to increase in proportion to the improved circumstances of the people. For instance, from 1840 to 1870 the percentage of infantile mortality rose from 15.9 to 24.7. *Ibid.*

• **TO THE PHARMACISTS AND PHYSICIANS OF MISSOURI.**—The Committee on Drug Adulterations, appointed annually by the State Pharmaceutical Association, and consisting this year of H. M. Whelpley, St. Louis, J. A. Gallagher, Kansas City, D. L. Haigh, St. Louis, R. T. Thornton, Rich Hill, R. S. Hughes, Odessa, earnestly request the assistance of the members in their important work.

A cordial invitation is also extended to pharmacists not members of the Association, and to the physicians of the State to assist in the work. At the last meeting of the State Association, the Committee on Drug Adulteration was instructed to extend this committee to any extent deemed proper, and to interest the pharmacists and physicians of the State in the importance of its work, and the direct good accruing from it.

It is the intention of the committee therefore to try and ascertain as far as possible how near the official substances dispensed in this State conform to the requirements of the United States Pharmacopeia. If each druggist in the State would select one official substance, and procure a sample in his vicinity and apply to it the pharmacopeial tests, the sum total of results thus obtained would be of incalculable value. The tests of the United States Pharmacopeia are simple, and especially adapted for use in retail stores.

It is not desirable that the report of this committee shall be composed of intricate chemical analysis of substances of no special interest to druggists, but it is earnestly desired that it be a report that represents practical value to each druggist and physician in the State.

Reports of work done for the committee will be tabulated and read before the Association at the next annual meeting at Pertle Springs, June 18, 1889, and full credit will be given to persons having performed the work.

Those who have articles suspected of adulteration, or otherwise, can send them to the committee if they themselves have not the time to examine them.

Address the chairman,

H. M. WHELPLEY,  
No. 113 Market Street, St. Louis, Mo.

**BLACK AND WHITE.**—In Alabama, a black negro girl, about eighteen years old, has given birth to twins at seven months, one of which is as "black as the ace of spades," and the other as white as any white child her medical attendant ever saw. This is as puzzling as the case recently reported, in which a beautiful young woman, with a tinge of negro blood so slight as to be imperceptible, married an unsuspecting white gentleman, and in due time presented him with a black baby.—*Maryland Medical Journal.*

**DR. HENRY F. FORMAD** has resigned the position of Demonstrator of Morbid Anatomy and Pathological Histology in the University of Pennsylvania.

**THE DEATH PENALTY BY ELECTRICITY.**—At the late annual meeting of the New York Medico-Legal Society the report was presented of the committee appointed in September to investigate and report on "The best method of executing the law punishing criminal cases by electricity."

Experiments have been made upon twenty-four dogs, two calves, and one horse, with both the continuous and the alternating currents, and the committee found that with the latter as low as one hundred and sixty volts would suffice to kill a dog, while with the continuous current a much higher degree of strength was required to produce a fatal effect. Death by the alternating current was without a struggle, while with the continuous current it was painful, and accompanied by howling and struggling.

The committee recommended that the criminal to be executed should be securely fastened in a chair, and that one electrode should be applied to the spine between the shoulders, and the other to the top of the head. A dynamo capable of generating an electromotive force of at least three thousand volts should be employed, and a current with a potential of from one thousand to one thousand five hundred volts, and with alternations of not fewer than three hundred per second. Such a current allowed to pass for from fifteen to thirty seconds would insure death.

After considerable discussion the recommendations of the committee were unanimously adopted as the voice of the Society. *Boston Medical and Surgical Journal.*

**LEAD IN WRAPPERS.**—Chocolates, confectionery, dried fruits, cheeses, and other alimentary products are very often wrapped in what appears to be and is described as tin-foil, but is really an alloy, containing a good deal of lead. This dangerous practice is now prohibited in France, and the tin-foil destined for this use must, under penalty, be composed of "fine tin," that is, an alloy containing at least ninety per cent of tin. This subject may be worth the investigation of public analysis.

**AN ARMY MEDICAL BOARD** will be in session in New York City, New York, from May 1 to 31, 1889, for the examination of candidates for appointment in the Medical Corps of the United States Army to fill existing vacancies. Persons desiring to present themselves for examination by the board will make application for the necessary invitation to the Secretary of War, before April 1, 1889, stating the place of birth, place and State of permanent residence, and inclosing certificates, based on personal knowledge from at least two persons of repute, as to American citizenship, character, and moral habits. Testimonials as to professional standing from professors of the medical college from which the applicant graduated, and of service in hospital from the authorities thereof, are also desirable.

The candidate must be between twenty-one and twenty-eight years of age, and a graduate from a *regular medical college*, evidence of which, his diploma, must be submitted to the board.

Further information regarding the examinations and their nature may be obtained by addressing the Surgeon-General U. S. Army, Washington, D. C. JNO. MOORE,

*Surgeon-General U. S. Army.*  
SURGEON GENERAL'S OFFICE,  
WASHINGTON, D. C., December 1, 1888.

**INCREASING MORTALITY FROM CANCER.**—Sir Spencer Wells said, in the Morton Lecture, which we published last week and the week before last: "Notwithstanding the great advance in sanitary science and the prolongation of the average length of human life—in spite of the shortening of the duration and the lowering of the mortality of some diseases, the prevention (almost the stamping out) of others—cancerous diseases, so far from being less prevalent or less fatal, are increasing among us. The increase in the number of deaths from cancer is now, and has been for many years past, greater than the proportional increase of population." And he proved conclusively that this increase is common not only to England and Wales, and in Scotland to nearly the same extent, but also in Ireland, though in smaller proportion. The correspondence between the Collective Investigation Committee of the British Medical Association and the Registrar-General will not be forgotten, and its importance was fully acknowledged by Sir Spencer Wells. The facts that the number of deaths from cancer in England had increased from 7,245 in 1861 to 17,113 in 1887, and that the proportion of deaths from cancer to one million persons living had increased from 360 in 1861 to 606 in 1887 in England; in Ireland from 350 in 1877 to 430 in 1887; and in Scotland from 404 in 1861-65 to 540 in 1881-85, are surely of extreme importance. They will probably surprise most of our readers. They have never before been so clearly put before us as in the second Morton Lecture.—*British Medical Journal.*

**TEMPERANCE AND TOTAL ABSTINENCE.**—There is a great deal of time and temper and type wasted over a perfectly useless discussion—the superiority of teetotalism over temperance. Half a loaf is better than no bread, and while our teetotal friends are sighing over the refusal of some of the best men of all creeds and parties to go all lengths with them in their great and noble efforts to abate the national vice, we hail every effort of any man to increase his own sobriety and the nation's. An honest coachman who reduces his beer to proportions which leave his head and his joints clear, and induces others to do so, is to us a valuable soldier in the great army of reformers. A man who abandons "nips" and public-houses, however respectably conducted, and restricts his alcohol to meal-times, shows a wonderful advance on the man who perseveres in such injurious modes of drinking. We confess to thinking the "well-conducted public-house" somewhat of an ideal conception. There are degrees of respectability in public-houses, and yet, with the growth of temperance there is a keener competition, which sometimes vulgarizes seriously even the better class of houses. The great thing for all to remember is that "nipping" and public-house drinking are mischievous, and contrary to all common sense and physiological teaching.—*London Lancet*.

**THE PHYSIOLOGY OF THE BRAIN.**—A valuable contribution by Professor Schäfer is contained in the forty-third volume of the Proceedings of the Royal Society: a comparison of the periods of latency of the ocular movements on the excitation of the frontal and occipito-temporal regions of the brain. Conjugate deviation of the eyes to the opposite side is produced by excitation of entirely different regions of the cerebral cortex. Of these parts, the frontal region is distinguished from the rest by the fact that its removal produces paralysis of that movement. This fact has been regarded by Ferrier as indicating an important functional difference, the movement in the one case being probably caused by the direct action of this part of the cortex upon the

center of origin of the nerves to the ocular muscles; but in all other cases by indirect action, the movement—when, for example, the visual or auditory region is stimulated—being the result of visual or auditory impressions, being provoked in the brain by the excitation, and these impressions producing indirectly the action in question. Professor Schäfer has found that the latent period is longer by some hundredths of a second in the case of stimulation of the occipital lobe or of the superior temporal gyrus than when the frontal area is stimulated; thus indicating that in the former case the nervous impulses must be transmitted through at least one more nerve center than in the latter. The additional center may be the frontal center itself, but this point requires further investigation.—*Ibid*.

IN Los Angeles, Cal., no one is permitted to practice medicine until he has signed a fee bill, and takes oath that he will abide by it. This prohibits him charging less than a certain rate, but does not limit him in placing an estimate on his own services. The custom is to collect at the time the services are rendered.

THE largest professional fee for limited service is said to have been paid to Surgeon-Major Freyer, of the Indian medical service, for treating the Nawab of Rampoor for three months' suffering from rheumatic fever. The Nawab gave him a lac of rupees, \$50,000.

A CODE OF VACCINATION RULES has been adopted by the Board of Health, Columbus, Ohio, in regard to the pupils and teachers in public schools. A system of house inspection has been adopted, and is being carried into effect.

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#### SPECIAL NOTICES.

**MARIANI & Co.**—The offices and warerooms of Mariani & Co. have been removed from 127 Fifth Avenue to 52 West Fifteenth Street, New York, where they will be happy to receive the members of the Medical Profession, and from where all correspondence will have prompt attention.  
MARIANI & CO.

**GONORRHEA.**—Robert S. Anderson, M.D., Spennymoor, England, says: I have found your S. H. Kennedy's Extract of *Pinus Canadensis* of great service as an injection in cases of gonorrhoea.

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÂ."

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[NEW SERIES.]

*certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them, and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.*

## Original Articles.

### SOMEWHAT ON THE TREATMENT OF LUNG FEVER.

BY RUFUS W. GRISWOLD, M. D.

In several places, within the last three or four years, I have noticed articles setting forth, with accompanying statistics, the admitted fact that the average success of treatment of acute cases of pneumonia in some of the large hospitals in the country is not as good now as formerly; in other words, more cases out of a given number treated die than there used to, say thirty or forty years ago. I think this statement is not denied; the records give the proof, and can not be gainsaid. Whether or no the like is true in the average private practice, take the States through, would not be easy to determine. There is no way to get at the figures relating to the percentage of deaths bulked together under the care of the sixty thousand or more practitioners in the land, and there is only a sort of general impression to make conclusions from; and, of course, that is not reliable as a basis of positive statement. But it certainly is the general impression in the minds of the older practitioners in this section, which has its basis in the observation of long-continued experience, that the average outcome in the treatment of lung fever at the present is not as good as it was a generation ago, and that the hospital figures are a nearly correct index of results in private hands.

Accepting as true what is by the statistics indicated, it becomes worth while to ask why it is that the average fatality in lung fever cases is greater than formerly? With our boasts of the great general progress in all matters pertaining to medical science in the last three decades, and our much talk of more scientific handling of diseases of all sorts, it ought to be somewhat humiliating that in the very common disease of lung fever we have not advanced in successful treatment, but retrograded. The character of this disease is such that a large percentage of fatality is inevitable, especially with the very young and the aged, no matter what sort of treatment may be pursued; but it will be agreed that in good results we ought not be behind our predecessors in the science and art of healing with this disease. Why are we behind?

I propose endeavoring to somewhat answer this question, but with the consciousness that the ablest of men would not be adequate for a satisfactory solution, and that an ordinary common-place practitioner can not expect to meet the matter with conclusive acceptance. But I hope to come at some of the bald points in the subject, and so perhaps put some better man into a further elucidation.

Many men who were in practice forty years ago will tell us there have been marked changes in medication. Some of these have grown out of a change in regard to the nature of fevers. Two generations ago, and for a considerable period, the doctrine obtained that nearly all fevers were inflammatory. Typhus was reckoned an inflammatory disease; and, being so considered, the proper course of treatment was by depletion, with intent to lessen the pulse and cut the

fever down. Tartarized antimony and venesection were potent remedies. Frequent and copious bleedings were in vogue, and were practiced as the rule. The class of fevers now generally called typhoids were as systematically bled as were the pneumonias and the pleurisies. The pendulum of medical opinion and practice swung strongly in that direction; blood-letting became too common and too indiscriminate, and the result upon that general class of fevers now considered essential rather than inflammatory was not for good. Looking back from our present standpoint, it is not difficult to conclude that our predecessors of that time bled and otherwise depleted quite too much for the good of their general typhoid or typhus cases. After a few years they began to discover this, and there came a reaction. Along with this arose a class of physicians, generally illiterate, but with enough keenness of observation to discover the error that better educated men had fallen into, but not with the judgment to any better discriminate the broad difference etiologically of a typhoid type of disease from an inflammatory one; so it came about that the potential factor for good in the inflammatory diseases, but sometimes of evil in the essential fevers, was condemned and finally discarded in both alike. For the last twenty years, over large portions of the country, and probably over three quarters of it, the lancet, in the treatment of any class of fevers whatever, has almost entirely gone out of use. Indiscriminate employment has been followed by the equal folly of indiscriminate abandonment. A sort of general acquaintance with the methods of the physicians among the six hundred thousand and odd people of Connecticut enables the writer to say that a large portion of the doctors do not use the lancet at all, and that those who use it do so but very little indeed, and only in rather extraordinary conditions. Indeed, it has for the last forty years, in all the regions hereabout, and not less so in various other sections of the country, been held by the general public that to bleed a man sick with any sort of fever was not

only to favor death but to make it almost certain. Before the pressure of this error medical men have been driven to yield their convictions in prescribing and doing for many patients sick with acute inflammatory troubles, with the general results (so far as cases of pleurisy and pneumonia are concerned, and of some other inflammatory diseases as well), that the percentage of recoveries in those diseases does not average up so well as aforetime they did. The legitimate conclusion from this construction of the matter is, that our predecessors were wrong in their too frequent and other depleting methods, as a rule, in the essential or typhoid class of diseases; that, as the rule, that sort of treatment averaged better in the acute inflammatory complaints than our present so-called scientific methods do; that we have made some gains on them in our management of the former class of troubles, but have fallen behind them in successful efforts with the latter. If the hospital figures that have been going around in the medical papers disclose the truth—and I have not observed any contradiction—that truth has its reasons behind; one of those reasons I have here endeavored to present. It is quite worth looking at; for a falling off in the percentage of recoveries in cases of so common a disease as pneumonia is a serious matter in itself, and not creditable to the men who do the prescribing.

It is likely true that in a general way we have, lumping us together, been prescribing for our cases of pneumonia in a quite different style from that in vogue thirty or even twenty years ago. To a large extent the departure from the older way has come from a change in the view some of us have been led to take of the etiology and general character of the trouble. It used to be almost, one might say altogether, held that a pneumonia was an inflammatory disease, an inflammatory fever, an acute inflammation of lung tissue; that the inflammation was the initial step, and all the phenomena exhibited followed the inflammatory action. But we have in later years come to be told

that this old view was all a mistake, and that lung fever, or acute lobar pneumonia, as the new lights call it, is not an inflammatory disease but an essential fever, like typhoid, and entirely dependent for its origin upon a colony of microbes in the lungs; and that we should tackle it from an entirely different standpoint from what we did in the older days; in short, we should treat it more after the general manner in which we treat typhoid, and that any remedies in the way of depletion, like the exhibition of antimony or the use of venesection, are entirely to be discarded; but that the thing to do is to build up the general system against the weakening potency of the microbe, and, if possible, kill him by throwing stimulants and quinine at him in big doses several times a day. Well, we have been traveling in that new path which the experimental scientists, or the scientific experimentalists, have blazed out for us, and the result is that more of our pneumonic patients die than when we groped along blindly on an erroneous basis! Isn't that so? Certainly it looks that way; and the uncontradicted figures show it. My impression is, that in the hospitals, where the fatalities have admittedly increased, the doctors in charge have been following the new path and prescribing from the new standpoint. It is time some obscure old duffer on the outside called for a halt, and asked for a reconsideration on the pathogeny of pneumonia; for it is out of the increased prevalence of this new delusion that a change of treatment has grown, and to which the less percentage of recoveries is fairly and rationally to be traced in a considerable degree.

Let us see what the new lights say as to the etiology of acute lobar pneumonia. At a medical sit-down of some of the most brilliant doctors of the commercial metropolis, some three years ago, they undertook to wrestle with this question: "Is acute lobar pneumonia a primary local inflammatory disease, or is it an essential fever, the pulmonary affection being secondary thereto, constituting its anatomical char-

acter?" Of course there followed a learned discussion, and the verdict, in which the men present nearly all agreed, was (abbreviated) about this: "Acute lobar pneumonia is characterized by an enormous exudation. . . . It is never referable to any appreciable local condition. . . . Ordinary causes of local diseases (inflammations) are not capable of producing it. . . . The traditional belief that the affection may be produced by a cold is without foundation. . . . That a special or specific influence is invariably the cause of acute lobar pneumonia is rendered probable by its occurrence at certain seasons, greater frequency in certain climates, and occurrence at times as an epidemic disease." And the deduction was that the "specific influence" was the so-called pneumo-coccus of Friedlander and other microscopic investigators, found in the sputa of patients having lung fever; and, by the way, also found by other investigators in normal human saliva. In other words, acute lobar pneumonia, which very smart men seem always to be able to differentiate from catarrhal or lobular pneumonia, but which is the kind our patients who die of any sort of lung fever mostly have—and the fatal kind—is not an inflammatory disease, coming from exposure and taking cold, as we used to "traditionally believe," but is an "essential fever," like typhoid, and "invariably" depends upon a colony of bacteria, which are having a fine time in the lung, and setting up there an irritation that finally becomes "anatomically characteristic."

Now it is quite safe to say that if any ordinary practitioner, any but a "learned authority," had undertaken to promulgate this theory in the way the distinguished gentlemen put it, he would have made of himself a subject for the ridicule of sensible physicians; but if one of the authorities presents us with something new and strange, the way is to open the mouth a little wider than usual and gulp it down at one swallow, without first masticating it and trying to see if it is rationally good for any thing.

The limit of the present paper does not permit going into a thorough examination of the so-called reasons given for entertaining this new-fangled notion of acute pneumonia's being an essential fever. In another place I have entered into the matter somewhat at large; and I have the egotism to think that my views will meet the indorsement of ninety-nine of every hundred of the physicians of the country. The views were, or are, that a pneumonia is an inflammatory disease, the outcome of some careless or unavoidable exposure of the system, such as standing in a draft of cold air, or going out, without proper protection, from a heated room into a cold one, or lying down on the wet ground, etc., and that the notion of a coccus being "invariably" at the bottom of the trouble is all bosh. My view has nothing at all new in it; it is solely a holding on, perhaps a pig-headed holding on, to the old conviction that has obtained with the profession for two thousand years and more, that observation down all the ages has confirmed and reconfirmed, and that is illustrated over and over every day in every section of the world where pneumonias present themselves.

Let us look a little at one reason given by learned gentlemen for adopting the notion that pneumonia is an essential fever and dependent upon a specific coccus, to wit: "That a special or specific influence is invariably the cause of acute lobar pneumonia is rendered probable by its occurrence at certain seasons, greater frequency in certain climates, and occurrence at times as an epidemic disease." The reason, or rather the three reasons here given, because of the antagonistic differences in them, are divided into two parts; and first, "occurrence at certain seasons" and "greater frequency in certain climates." The propositions here made are correct; the rational deductions from them are exactly the reverse of what is claimed; they do not argue the existence of a microbe, they do not in the least evidence it, but they stand over against any such conclusion. Pneumonia is emphatically a disease of the colder climates and

of the colder and stormy parts of the year in those sections of the world where it is frequent. In our own latitude the especially summer months give us very little of it; the eight months from the first of May show much less than the four from the first of January. It is a winter disease; and in those seasons of the year and under those conditions of weather and climate when microscopic life is claimed to be most active and efficient of evil the trouble is very much less frequent, and almost entirely disappears for the time being; which, if it evidences any thing at all, emphatically backs up that traditional belief which the new lights would have us believe is nothing but nonsense and humbug.

I have said that the reasons, as last above quoted, to sustain the cocci theory divided into two antagonistic parts. There is some plausibility in one of these, to wit, "Occurrence at times as an epidemic disease." In the discussion to which I have alluded, this is the sole colorable reason standing behind the conclusion arrived at. I have not encountered an "epidemic" of pneumonia, properly speaking, but that is no evidence that such do not occur. There are epidemics of the disease, properly speaking; that is, there are occasions when the disease prevails in isolated sections to the extent and in the way that *seems* to legitimately argue the influence of some specific cause, and in which it is rational to conclude there is some other factor engaged than those ordinary ones that produce the sporadic cases of lung fever. We have an epidemic influenza in the same way. Another patent illustration of a somewhat similar influence is afforded by the so-called epizootic that attacks horses in various sections now and again. And it is right here that the pneumo-coccus of Friedlander may find place. Do we then get pneumonias from different causes? Certainly. Don't you get a copious flux from the nasal passages often from standing out on the wet ground in thin slippers? and won't a pinch of maccaboy give you the same pathological exhibition? And do you know of any way in which the chemical

difference between the flow in the two cases can be distinguished? Physiologically, pathologically, anatomically, chemically, there is no difference; but etiologically and clinically there is much. The cause of the flux in one nose is entirely different from the cause in the other nose; and in your treatment of the cases, if you proceeded upon sound and rational principles, you would have regard to the etiological difference and make your therapeutic efforts in accord. So, also, if you regard your acute pneumonia as an inflammatory disease, your general therapeutic endeavors will be from a basis very different from that which you will adopt if you regard it as an essential fever. In accord with this, grounded on the delusion that acute pneumonia is invariably the outcome of a colony of cocci in the lung tissue, and is to be treated as an essential fever, we have been led in the general way to a system of treatment quite different, and on a principle antagonistic to the older mode; and in that new departure we have one of the obvious reasons why our hospital records present us with the humiliating truth, that in the treatment of the disease, so far as success is concerned, we have gone back of the figures of our predecessors.

I do not sit down to recommend a return to that, perhaps, indiscriminate employment of the lancet in which the doctor of forty years ago indulged; but I do believe that we have as irrationally erred in its utter abandonment as he did in its too often employment. I shall not undertake to advocate the exclusively depletive treatment of all cases of lung fever as being the best; but I do believe that we have gone far astray in altogether substituting for it the stimulating and specific tactics based on the absurdity of an etiological bacterium. My impression is that those hospital figures on the percentage of recoveries in cases of pneumonia, which we can not read with pleasure, are due in large degree to the new departure herein considered; and a rational conclusion is that it is high time for our teachers to give the subject a reconsideration.

### A CASE OF EMPYEMA.\*

BY AP MORGAN VANCE, M. D.

Mr. M., aged forty-two, is a patient of Dr. Thos. R. Walker, who was called to see him August 27, 1888. The doctor received this history: the patient had been the subject of no serious illness except an attack of pneumonia, six years ago (Dr. Wm H. Long attending him), and another five years since, in which Dr. F. C. Wilson saw him. Family history quite good. The present trouble had existed an indefinite period, that is, he had had pain and an uncomfortable feeling about the right side of chest for quite a number of months. Gave up work (driving a street-car) on above date on account of cough, pain, and difficult breathing. Dr. Walker found him with some fever, not high, and great pain and tenderness of whole of right side of chest. So great was this soreness that the man could not turn or be turned in bed, therefore a complete examination was not obtainable. There was considerable dullness of the anterior part of this side of the thorax. He treated the symptoms, not making a complete diagnosis, but supposed he had to deal with a case of pneumonia. Blistering and hot applications relieved all active symptoms except the difficult breathing. A few days before I was called in consultation, September 11th, the doctor was able to make a very thorough examination, and found extensive dullness over almost all of this side, and supposed there was a large accumulation of serum in the pleural cavity. There was then no fever—possibly 99° in the evening—and there had been none for several days. From the history I agreed that there was a pleurisy, and tapped posteriorly through the seventh or eighth intercostal space, both of us being surprised when pus came through the rather large needle used. A full aspirator bottle came away, when the needle became clogged and was withdrawn. There was quite a degree of relief followed the tapping, and there was a little increase in the area of resonance anteriorly. Dr. Cartledge

saw him in my stead during the next week, as I was absent from the city, and he was sufficiently comfortable for him to advise the postponement of any further operation until my return. I saw him again on September 23d, and advised resection of a rib and thorough drainage, but, as a compromise, the next day endeavored to put a cold tube between the ribs by the aid of King's instantaneous tracheotomy instrument. I failed to get into the cavity. The patient then consented to the resection. On October 1st, assisted by Drs. Walker, Long, Griswold, and Houston, I removed, subperiosteally, with an ordinary bone forceps, about three inches of what I took to be the eighth rib, first exploring with the aspirator needle. The opening through the pleura corresponded with the bottom of the cavity. A great deal of pus came away, much of it being in cakes, like curd. The cavity was washed out well with a large quantity of of warm bichloride solution, 1-5,000, the irrigator tube being pushed far in, so the gush of water would aid in bringing away these cakes of pus. A large double drainage-tube of rubber with rubber plate was fastened in the wound, and a complete antiseptic dressing covered all. The case progressed to a rapid recovery without one bad symptom. There was never any further discharge of pus from the cavity; the dressings, being soiled by serum only, requiring changing at first every other day. The tube was removed, and the patient allowed to sit up on the seventh day. There was no rise of temperature, and the only difficulty experienced was from nausea following the chloroform, or probably the removal of so much pus. The external wound, I understand, was completely cicatrized by the end of the sixth week, his lung seems to have returned to its full capacity, and to-day the patient is in his usual health.

This case proves to me the great advantage of thoroughly cleansing the cavity in this class of cases as early in their progress as possible, before the lung has had time to form adhesions or to become contracted.

Try the aspirator first for diagnosis and possible benefit, but do not wait too long before giving a large vent to the pus and washing out the sac.

LOUISVILLE.

## Societies.

### LOUISVILLE SURGICAL SOCIETY.

Stated Meeting, December 3, 1888. J. M. Mathews, M. D., Vice-President, in the chair.

Dr. Ap Morgan Vance presented the following case:

Patient a young man. Last June a year ago, while riding between two box cars, he fell between them, and it seems that the train ran over his shoulder. I saw him twenty-four hours afterward, and found a great amount of ecchymosis anteriorly and posteriorly over the injured part. The scapula, clavicle, two or three ribs, and the head of the humerus were broken. I thought the patient would not survive the injury, but on the ninth day he was up and about. The chief point of interest in the treatment was the making of an artificial joint for the humerus. I reported this case at a meeting of the Medico-chirurgical Society at a time early in its history. Some of the Fellows held that it was impossible to get motion after such an injury in a young person; but, as you see, he has considerable motion.

Dr. Vance read the essay of the evening: A Case of Empyema; Operation, Resection of the Ribs. (See p. 37.)

### DISCUSSION.

Dr. W. L. Rodman: The results obtained by the essayist are better than is usual in such cases, there having been less sinking in of the chest. In children, especially, there is considerable sinking in of the chest wall. It is clear that the operation of Dr. Vance is the best to be done when the surgeon is satisfied that pus is present. I believe it useless to operate more than once. In the treatment of a case of this kind there is but one curative measure, thorough evac-

uation of the cavity. We may make a free opening by resection of the rib, which I think is the better, or put in a tube for permanent drainage. In cases where the parents will not permit resection, the tube operation can be performed. In the last case I saw there was a large collection of pus (two quarts), and by making a free incision into the pleural cavity, putting in a drainage-tube, and washing out the cavity with an antiseptic solution, the patient got along very well. However, the best results are obtained by resection of the rib.

Dr. E. R. Palmer: For many years I taught diseases of the chest. The great problem, I remember, when I first began this work, was how to get a tube into a pleural sac and so manipulate it as to keep the air out. I was in the habit of warning my students against the danger of letting air into the pleural cavity. We know that laparotomy is to-day done frequently and without fear, and I think it would be well if we could hear oftener of the free opening of the pleural sac in all such cases as this, done with that fearlessness with which the abdominal cavity is opened. I think the time has long since passed when men pinch their tubes and use stop-cocks to prevent the entrance of air into the pleural sac.

Dr. H. H. Grant: I have but little to say about the operation of resection of a rib, as I have never had occasion to do it, but I think, especially in children, very beneficial results are gotten from tapping the pleural cavity for serum or pus. The necessity for resection of the rib probably would only occur in the minority of cases in which it was necessary to tap the cavity. I have never seen a case where any evil results were obtained after tapping the pleural cavity, and I shall, in the future as in the past, unhesitatingly tap with an aspirator all such cases. I think the aspirator will often settle the diagnosis in children when it can not be made out by percussion or auscultation.

Dr. Palmer: Suppose you find pus?

Dr. Grant: I would drain it away by opening up the cavity.

Dr. A. M. Cartledge: This is a very interesting case, and the results are very good. I have had some experience in this operation. Two years ago I read a paper before the Medico-surgical Society on resection of the rib for empyema. Since then I have had one case that proved fatal, though this is no argument against the operation, since the case was tuberculous and desperate.

The principle feature of Dr. Vance's report was the use of bichloride of mercury injections into the pleural cavity. This is the first time I have heard of this solution being used.

On account of the great flow of pus after resection of the rib in these cases, it was first thought impossible to keep out the air. I did it in one case satisfactorily, using absorbent dressings, in this way not permitting the pus to become contaminated. There was no subsequent rise of temperature. As an antiseptic I used carbolic acid. For a long time there was an objection to even injecting water into the pleural cavity; and many surgeons made it a rule not to inject any thing into the cavity at all.

Dr. Vance's case is an excellent example of what this operation will do for a bad case. Even in those cases where there is great retraction of the lung, and great accumulation of fibrous tissue, the resection of two and a half or three inches of rib, with thorough cleansing, I believe, will be followed by recovery.

In regard to the division of these cases as to treatment, I am in favor of aspiration in children, as there is no doubt cures may be effected in many cases in this way.

There is no question but that purulent accumulations in the pleural cavity in adults are at times cured by aspiration; such cures are rare. There was one case which I saw with Dr. Marvin, however, in which we drew off a gallon of purulent secretion with the aspirator, and there was no re-accumulation. This shows that occasionally this measure will prove curative.

Dr. William Bailey: There are two points that are extremely favorable in this case, and I apprehend Dr. Vance will never re-

port so favorable a case again. The first is the non-tuberculous character of the disease, and the second is the admirable condition of the lung, in which full expansion seems to have been allowed. I find no evidence of impaired respiration. The lung seems to have been restored to its full function. I take it that it is, as Dr. Cartledge says, an ideal result, and I do not think the doctor can look for so good results again, no matter how long he may practice. Some sixteen years ago I remember we had a visiting surgeon here, Dr. Stone, of New Orleans, who lectured upon resection of the rib as a means of treating empyema. If I remember rightly the operation was not altogether the removal of the rib, but just half of it. That was advised instead of cutting out the whole rib, and he claimed that it was the only proper method of treating empyema; otherwise, if the entire rib was removed, the shrinkage would be so great that it would be impossible to secure thorough drainage. I think that in all cases one could afford to try aspiration, inasmuch as occasional good results have been thus obtained.

Dr. Vance: I believe, with Dr. Bailey, that it is seldom a man meets with a case showing results so perfect, and I think the good result was due to the perfect cleanliness observed during the operation. Bichloride of mercury, 1-5,000 solution, was used, and I believe at least three gallons were run through the cavity. Besides that, the tube and dressings were aseptic. I do not think there was any pus from the cavity afterward. I think we should do the operation as soon as we can get consent, after pus has formed and the operation determined upon. I believe, however, that cases can be cured by aspiration. I do not see, when pus will flow through the needle and not become clogged, why an abscess here will not get well as in other parts of the body; but I believe, for the reason that long pressure of this pus or serum would damage the lung, the sooner we get through the better will be the result. This man has certainly improved greatly. He was a very

shadow of what he now is when I operated. This rib was resected subperiosteally. I do not believe that any body states this to be a point of advantage. I think one would get a good rib if the periosteum be preserved. I slipped the periosteum back, and then resected the rib inside, letting the incision be in the line of the periosteum outside. I am inclined to believe there is formation of bone, because there is no cavity or shrinkage.

Dr. Rodman: As the use of bichloride of mercury in such cases has been in question to-night, I would say that I saw Dr. Yandell flood the pleural cavity with this solution two years ago at the University clinic. The man left the day after the clinic, however, and I have not heard from him since.

#### ORAL REPORT OF CASES.

Dr. Bailey: A few days ago a boy was brought to my office, having received a cut just above the brow, about an inch in extent. It was pretty deep, and yet the parts did not seem to be much injured. In order to close the wound I took a stitch, which was made with a fresh needle and clean silk, but not made aseptic. I supposed I would have no trouble. I waited until the second day to take away the stitch. I found in the meantime that the eye had become closed, and the whole lid seemed to be edematous, but it was simply a pus sac, which in some way had formed in the two days. When I cut the stitch the pus welled out of its track. I emptied the abscess very completely, and I have never seen any pus since; simply a little staining of the cloth which I wrung out of hot water and applied without any antiseptic at all. I kept up constant applications of hot water, and there has never been a reaccumulation; practically it was well in three days. The question is, why was there no return of pus when no antiseptic was used?

Dr. Palmer: I saw recently in a medical journal the statement that in carbolic acid (strong solution) germs will grow, and that bichloride solutions, stronger than we ordinarily use, will still allow germs to grow;

that there is but one perfect antiseptic, and that is boiling water, and I think the free use of this boiling water did the work. I do not see why the doctor should have had no pus afterward, unless he removed the cause by complete cleansing of the cavity with boiling water.

Dr. Vance: I believe it was the pressure that did the work. Better coaptation of the parts, so that there was no room for any more pus, and the sides of the wound came together by granulation. What did form afterward was taken up by the dressing. I would advise in such a case the use of catgut instead of silk.

Dr. Grant: I prefer silk to catgut in such cases. I think, if the doctor had continued to wash out that cavity with an antiseptic solution he would have continued to have pus.

Dr. Vance: I believe that I can wash out a suppurating cavity with an antiseptic solution and not have any re-accumulation of pus in it, even after it has contained pus for some time.

Dr. Grant: That is not what I meant. Where the microbe of pus has become inoculated it is difficult to eradicate it, and when the wound is left so that air can get to it, it will continue to suppurate. The object is to open the cavity, let out the pus, and get union by granulation instead of by first intention.

Dr. Turner Anderson: I think it is a matter of common observation in wounds about the brow, that we have a very considerable amount edema. I think also that where we have once opened the wound, let out the pus, and dressed it antiseptically, that we have no more pus, and that the wound heals by granulation. I think Dr. Vance has given the explanation of it.

Dr. Palmer: Do you think that the development of pus in an injury about the eye can occur and the surgeon not be at fault, if he has the case from the start?

Dr. Anderson: I think, as a rule, he will not have pus. If he dresses the wound antiseptically in the strictest way possible, I believe he would get wounds of the face to unite without the formation of pus.

Dr. Palmer: Did you not, twenty-five years ago, refuse to use any sutures on the scalp for fear of erysipelas?

Dr. Anderson: I never sew up the scalp. I have abandoned that practice entirely. I certainly would not use a suture if I could get a reasonable coaptation of surfaces.

Dr. Cartledge: Why would you not use sutures?

Dr. Anderson: Because in the last few years I have found that I am more apt to get union by first intention than if I introduced a foreign substance.

Dr. Cartledge: That rule would hold good in the days when they did not thoroughly cleanse the parts, but in these days I think it is no more dangerous to use the suture here than in any other part of the body.

Dr. Anderson: I think sutures here are unnecessary. I remember a man with fracture of surgical neck of humerus, and a very ugly scalp wound. After properly shaving his head, I simply used rubber adhesive plaster, coaptating the surfaces nicely, and applied a cloth soaked in an antiseptic solution. After four days I removed the dressing and had union throughout. I asked Dr. Yandell the other day if he used sutures in scalp wounds. He said he was discarding them in many cases, that he found them often unnecessary.

Dr. Vance: In regard to suturing the scalp, I do not believe it does any more harm than in other places. If you would avoid the scar of the stitches you can do it by putting adhesive plaster on either side, and sewing through that, getting also good approximation. I have sewed up scalp wounds of great extent and never had any trouble. I have used catgut without ill results.

Dr. Rodman: There is one point not mentioned in this discussion, the depth of the wound. If the wound is superficial to the deep fascia there is little danger of suppuration. If this fascia is opened, there is great danger of this result, whether sutures are used or not. In a great many cases you can not get union by first intention without using sutures. The trouble is, that serum gets under the occipito-frontalis muscle, the

air comes in contact with the serum, and wherever you have air coming in contact with any discharges which are pent up you will have suppuration.

Dr. Anderson: I want to be understood as saying that I shave the scalp and dress the wound antiseptically, and that I do not use sutures in scalp wounds because I think they are unnecessary. I am not afraid of sutures anywhere.

Dr. Grant: It is a noteworthy fact that scalp wounds have more vitality for repair than wounds elsewhere on the body; not only for repair, but for reproduction of tissue. The position taken by Dr. Anderson is a very rational one, that wounds in this situation, by their own tendency, heal by first intention, or, if not, by granulation which produces very little pus, and get well in a short time, and that the necessity for putting in stitches is done away with by the provision already made by nature. While it is more convenient in many cases to put in stitches than to shave the scalp, I am satisfied that in many cases where approximation is not perfect, and where the patient is not seen in time to achieve the purpose of getting union by first intention, you can obtain good results by putting on a bandage even without plaster. I am not sure that the danger of suppuration is done away with even where the occipital fascia is not opened, and you must encourage drainage by leaving the wound open so as to prevent infection of the brain.

Dr. Vance: Do you not believe you could cut a large piece out of an arm, and that the wound would heal without pus?

Dr. Grant: No, I do not believe it could be done.

Dr. William Cheatham reported two cases as follows:

One is a case of what I suppose to be brain tumor. Child ten years old, who for six or eight weeks has been complaining of that form of headache so often observed in brain tumor, not enough to make the child cry out, but quite marked, lasting for four or five days, then a rest, then coming on again. The case was sent to me by a gen-

tleman who had practiced in diseases of the eye for some time; he thought it was a case of glaucoma, but the ophthalmoscope revealed a tremendous choked disk. The optic nerve stuck out half way into the vitreous, every sense being perfect except the loss of vision, with history of headache.

Drs. Marvin and Yandell saw the case with me. Dr. Marvin was in doubt as to the nature of the case. Dr. Yandell and I saw a case several years ago with a similar history, and exactly the same condition of things. The child died four days afterward.

Another case was a shot wound of the eye. One or two shot entered the eye. The person firing must have been quite a distance off, and we usually consider shot entering the eye under these conditions as aseptic. One shot struck the sclerotic coat, and at first it was thought it had gone through the sclero, but we discovered it had not. The point I wish to call attention to is the use of the ophthalmoscope in the case. After cocaineizing the eye, the probe followed the shot entirely around the sclero.

#### DISCUSSION.

Dr. Vance: In regard to lead my experience has been, when a bullet goes into a part, having struck that part without having gone through clothing and carrying clothing with it, we have little or no pus, but when clothing is carried in with the shot we nearly always have pus.

Dr. Cartledge: It has been my experience that lead under these conditions is innocuous unless it carries other things in with it.

Dr. Palmer reported a case as follows:

I have two patients, two boys, probably twenty or twenty-three years of age, sons of a father who believes in his boys, and between whom and his boys is an absolute confidence. The youngest is under treatment for syphilis. The oldest came to me with enlargement of the lymphatic glands in each groin—very pronounced enlargement. I questioned him thoroughly as to the possible cause of the enlargements. He could give no history. I went to Henderson and left

the boy, diagnosis on my part being imperfect. During my absence he went to a doctor in town who thrust an electrode into each gland and passed a pretty strong current with a view of dissolving the enlargements. He came back to me with quite a large scar from the puncture and no change in the glands. I questioned him very closely, and then examined him from head to foot, and could see no way in which the trouble could have originated.

His father came to me next day and asked if his other boy had the same trouble. I was satisfied it was not syphilis. I said, "I am free to tell you that I do not know what is the matter." He said, "Doctor, that boy's bowels have not moved for ten days." I said, "You go home and give him injection after injection of hot water, without any soap, until you get his bowels thoroughly emptied, and keep on until you have relieved him of what must have accumulated during that time." The boy came to me sometime afterward; he said his bowels were all right. I put him on his back, examined him thoroughly all over the abdomen, and on account of the large amount of fat could not tell whether there was any accumulation of feces or not. I then put on the double spica, and kept that up for about two weeks. Finally, about a week ago, I ordered some mercurial ointment. He came back to me with glands considerably reduced in size. There was no trouble that I could see except this multiple enlargement of the glands of the groins. I was exceedingly hopeful that the impaction of feces was the cause of the trouble. I am certain the boy has no syphilis; he is perfectly healthy, there is no point of infection discernible, and absolutely no history of syphilis.

The question is, what brought about those enlargements? There is no possibility of any strumous condition, and I am anxious to know what is the cause.

Dr. Anderson: Why were you so particular to discard soap?

Dr. Palmer: Because I was told by Dr. Mathews never to use soap in enemata.

Dr. Vance: Are these enlarged glands limited to the region of the groin?

Dr. Palmer: Yes. I have examined the knees, thighs, legs, neck, etc., and have found none. In each groin he has prominent glands with satellites around them.

Dr. Cartledge: Is there any irritation around the foreskin?

Dr. Palmer: The foreskin is perfectly clean.

Dr. Anderson: I remember, several years ago, that we had quite an epidemic of adenitis. I think we saw many cases of idiopathic inflammation of these glands. I think this case is simply one of idiopathic adenitis. We usually have a specific cause that is responsible for these inflammations of the glands of the groin, but, as I have said, several years ago we had quite a number of cases occurring wherein we were unable to trace the cause of the inflammation, and we had simply to consider them cases of non-suppurating, idiopathic adenitis. I think that possibly this case belongs to that category.

I do not see how constipation could have produced it. I do not know that in women we ever find inflammation of these glands as the result of constipation. We know, of course, that in womb troubles, inflammation of the ligaments, etc., and where the lymphatic structures are inflamed we have enlargements of the glands of the groin, but I do not see how constipation could have produced the enlargement.

Dr. Grant: I have seen quite a number of cases in which the inguinal glands were enlarged. I remember to have seen bilateral enlargements (other than those due to syphilis) in but one case, and I believe that in this there was some hidden cause for the enlargements. Some two years and a half ago I saw a man with enlarged glands on each side, existing for two or three months without doing any thing for them; they became so painful and large that he applied to me for treatment. I made several external applications without good results, so I put him under chloroform and removed the glands. He has had no trouble since. I could never get out of the man any his-

tory of syphilis. He is a married man, and in good health at the present time. The cause of the enlargements I never could find.

Dr. Cartledge: I dislike the term "idiopathic," but I believe, when we come to the question of adenitis in various portions of the body, we are forced to sometimes accept the term. I have seen them, and looked and looked again for the cause, and could not find it.

As Dr. Anderson suggests, there seems to be a period when they occur in groups, and you can not trace them to any cause in cases where syphilis and strumous history were out of the question. Many of these cases of adenitis seem to come under this head, "idiopathic." I remember having a case sometime ago, without any venereal history, a clean prepuce, etc. The patient had adenitis in the left inguinal region, going on to suppuration; no cause was apparent. I removed the gland, and it healed nicely. As I understand it, this comes under the head of the case Dr. Palmer describes, which seemed to be indolent adenitis.

Dr. Vance: I have a case on hand now which seemed to be caused by the man's having to carry large, heavy weights across the groins.

Dr. Rodman: I have a case under treatment exactly like the one reported. The man had a bubo on each side, above Poupart's ligament, with no tendency to suppurate, and under treatment by spica I do not think they are going to suppurate.

I have had a number of cases where the buboes were double, one case was referred to me by another physician. I was very careful indeed to get from the man a non-specific history. He disclaimed the possibility of the trouble's being specific in any way. I had him under observation for four or five months, and am certain it was not specific. The glands went on to suppuration, and both had to be opened. In another case, which went on to suppuration, the buboes were confined to one side.

I am satisfied all these cases were non-specific, and I believe, as Dr. Anderson says,

that they often occur independently of venereal infection. I believe, also, as Dr. Vance says, that they can sometimes be traced to traumatism, heavy work, etc., and that under these circumstances they will sometimes go on to suppuration. We can not understand these cases.

Dr. Cheatham: I wish to report my results in diphtheria when treated by intubation.

In my first fifteen cases I had but one success. I have now practiced it three years, and have had seven successful cases out of twenty-eight.

I think the first cases were a more malignant form of diphtheria, and probably I knew less about the operation. In operating now I keep the head lower than the feet, so that nothing foreign can enter the larynx.

E. R. PALMER, M D.,  
Secretary.

#### ALLEGHANY COUNTY MEDICAL SOCIETY.

Special Meeting, December 18, 1888, J. Chris. Lange, M. D., Vice-President, in the chair.

Dr. Duff reported a "peculiar case." I was called this evening to see a girl thirteen years of age. Two years ago she was down with inflammatory rheumatism. She came home last Wednesday, from school, complaining of slight pain in one of her ankles. There was no perceptible swelling, her mother said, but the pain increased slightly until Saturday, when the other ankle became affected. On Sunday a papillary eruption appeared on the first ankle, and on yesterday morning a very free eruption appeared on the other ankle. Yesterday afternoon the wrist and elbow on the right side began to swell and to pain her, and simultaneously with the swelling this papillary eruption appeared on both the joint of the elbow and of the wrist, and about this time the eruption became pustular upon the ankles. This afternoon she was taken worse, and simultaneously with the appearance of the pain the swelling on the other arm and papillary eruption appeared. This evening I found her with a temperature of

104°, pulse 120: pustular eruption on both ankles, and upon the elbow and fore-arm on the left side there is a mixture of papillary and pustular eruption; while on the right arm it is papillary. I do not remember that I have ever seen any thing like it. I report it as I found it, and would be glad to have the opinions of others. I have just been asked whether there was any local application made to the parts. I made particular inquiry about that, and the mother stated that there was not, except that she used a little camphor liniment.

Dr. Davis reported a case of amputation through doubtful tissues. About two weeks since a strong, able-bodied Pole was admitted to Mercy Hospital, this being his history: He was admitted on Tuesday. On the preceding Friday, while coupling cars in a coal-works near Punxsutawney, his arm was caught in the coupling and slightly crushed. He brought a letter from the doctor who attended him at the time, Dr. Williams, of Brookville, or Punxsutawney, stating that the blood-supply to the hand had no doubt been entirely cut off, and that he had urged amputation, but that the man had positively refused to have this done, and preferred to go to the city and get advice. The bandage on his arm, I presume, had been none too tight; when I saw it the hand was perfectly black. On looking at the arm, every evidence of gangrene was present. The arm was swollen to almost twice its normal size, with the peculiarly marked discoloration of progressive mortification, with the blistering down near the elbow. The line of demarkation had extended over the top of the shoulder. The resident at the hospital, who had seen him two hours before, assured me that when he had noticed it it was not within at least four or five inches of the shoulder, and yet in two hours it had advanced to the shoulder with a high elevation, so that by passing the finger over from the healthy tissue to the diseased, you could readily discern the line of demarkation. The man's temperature was about 105°, his countenance anxious, his whole appearance that of one who had suffered an extreme shock

to the system, and in whom disease was progressing rapidly. His condition was really critical, so critical that I felt that all hope of his life was surely gone. I called in some of the other gentlemen of the hospital, and we concluded, at all events, not to let the man die with that black arm, as an amputation was really the most we had to hope for. I amputated the arm at the middle by the circular method, cutting through tissue absolutely black, cutting down through the fatty tissue of the arm, and down to the muscular parts, the muscles having become not as yet thoroughly involved. I removed the arm, and then applied almost boiling hot water, and then bichloride solution, 1-1,000. I pressed out with the bandage as firmly as I could from the shoulder down all this material, and then filled the conical cavity full of iodoform, put a piece of cotton around, and left it. The man is rapidly improving, and will recover. I know that usually the surgeon who would have done this with any expectation of the recovery of the patient would have been considered very ignorant indeed; but I believe recovery was owing to the powerful antiseptics used, and to the use of the boiling water and the solution of bichloride.

Dr. Murdoch: A very interesting case, I think, has been reported by Dr. Davis, and one that is instructive to us all. The old rule in surgery in regard to amputations in such cases was, that in gangrene which arose from a constitutional cause, such as is the case in senile gangrene or as is the case where gangrene attacks a patient suffering from diabetes, to wait until the line of demarkation was formed. So also in some cases of gangrene resulting from local causes, such as frost-bite, the rule was to wait until the line of demarkation was formed; but in cases of injury, like the one related by Dr. Davis, I think that the rule was never thoroughly observed by the best surgeons, and that even the older surgeons advocated amputation in certain cases in vigorous patients while the gangrene was still progressing in cases of injury. But previous to the introduction of the antiseptic

tic method of treatment, no surgeon would have thought of amputating through or so near dead tissue as Dr. Davis did in this case, and if he had done so without such treatment he would not have been successful; the gangrene would have extended. For that reason this is a very interesting and instructive case. There is another point which is very instructive and useful, suggested to my mind by the report of this case. Dr. Davis tells us that the arm was bandaged very tightly above the wound, but he does not think the bandage had any thing to do with the gangrene. Whether it had or not, I wish to call attention to something that should be known and well observed by surgeons. It has been my fortune, since I have been connected with the Western Pennsylvania Hospital, and before, to see patients brought to the hospital with tourniquets on limbs pressing entirely too tightly above the wound for the purpose of arresting hemorrhage. I have seen several cases brought, where gangrene has resulted from the tightness of the bandage above the wound, applied in one case by a doctor, and in several other cases by those not professionals. I know of one case where a man was brought, not far from here, with a not very severe wound of the leg. A tourniquet had been on the thigh twenty-four hours, and the limb was in a state of gangrene. This was owing entirely to the tightness of the bandage. I have known several such instances, and also instances where patients have been brought with very slight wounds, there being only wounds of veins, the tight bandage distending the veins. Now these frequent accidents justify the belief that if there was none of this tight bandaging there would be more lives saved than lost as a result. I think more people are injured by the tourniquet applied to wounds than are benefited. This is my experience in these cases. This practice arises from faulty ideas in the minds of the people, which have emanated from the profession. The profession is accountable for the education which the people have, and the reason these cases are

frequent is owing to the fact that the public can not be instructed how to apply a bandage in case of a wound. We know there are books circulated in the community, and all over the world, that instruct the laity to apply, in wound of an artery, a tourniquet or tight bandage above the wound; in wound of vein, below the wound. These are the universal instructions to the people. Our policemen are so taught. The same is true of locomotive engineers. In wound of an artery, they will put the bandage above; in wound of a vein, they put the bandage below. They are instructed, further, that in wound of an artery the blood will be bright red, and will issue with a spurt and a whiz; that in wound of a vein the blood is black, and will issue continuously. These instructions are sufficient, perhaps, for a man who has gone through a medical college, the man who has seen a wound. Yet he may have seen very many wounds and still be mistaken in this particular. It requires a great deal of experience to enable one to distinguish between the blood from an artery and from a vein. The attempts to instruct men who are not professionals, who are not accustomed to observing severe injuries, result in more harm than good. The non-professional man, when he sees a wound, says to himself: "Now this may be a wound of an artery or a wound of a vein; I don't know exactly, but I will be on the safe side; I will put on the bandage above." Thus it happens that in every wound, severe or small, of vein or artery, the bandage is put on above the wound, and usually as tightly as it can be drawn. In nine cases out of ten these instructions result in injury. At a watering-place not far from this city, a little boy fell against a mirror and cut the veins of his wrist horizontally across. There were few gentlemen at the house, and the ladies were frightened; but there were some very intelligent gentlemen present. A tight bandage was put on above the elbow. The wound continued to bleed. Then they held the arm high up. It still continued to bleed. The boy bled for two hours, until the arrival of a physician. The physician stopped

the hemorrhage. He did it by removing the bandage. From like repeated experiences, I am of the opinion that the instruction being given to non-professionals results in more harm than help. If it be wise to attempt any teaching in the control of hemorrhage, I would advise these rules: If the hemorrhage be copious, and a bleeding point is seen in any wound, let it be covered by the finger point, and let this pressure continue until the arrival of a physician; if the bleeding be not copious, put a bandage, not above nor below, but *upon* the wound.

Dr. Batten: Dr. Davis was fortunate in the ending of his case. I had some experience in hospital gangrene in 1862 and 1863. Many of the wounded at that time were afflicted with gangrene. If the leg was wounded, the gangrene would extend around the leg and expose the vessels before amputation was resorted to; but the gangrene was not arrested by the operation. It extended. And in many cases re amputation above the knee became necessary. I believe the knowledge that is being sown among the laity regarding the care of the wounded is more harmful than beneficial. Persons not accustomed to handling wounds are timid; if they do any thing, it is as likely to be wrong as right.

Dr. Buchanan: I think Dr. Davis is to be congratulated on the success of his operation, but I think he is giving rather more credit to the antiseptics than is justified by the case. No one, I think, can be a firmer believer in antiseptic treatment than myself, but I believe that Dr. Davis rather overrated the influence of his antiseptic agents in this case. Either the flaps in the amputation were dead or they were alive. The outcome of the case shows the flaps were alive; but the antiseptic agents are not to be credited as preserving them. Either the lymph channels were swarming with bacteria or they were not. If they had been so swarming, I do not think any application of antiseptic agents would have destroyed the micro-organisms they contained. I believe the man was suffering from the presence of the decomposing member, and that when Dr.

Davis removed that, he removed the cause of the disease, and that probably if he had not used any antiseptic agent the irritation would have subsided as quickly.

I do not wish to be understood as saying that the outcome of the case would have been as favorable; in all probability he would have had suppuration and trouble, but, from the description of the case, I believe that the majority of men so affected would recover without antiseptic agents—not so nicely, indeed, but they would recover. I don't believe in giving more credit to the antiseptics than they deserve.

Dr. Duff: It is of importance, very frequently, that the non-professional who may witness an accident involving dangerous hemorrhage shall possess the knowledge and skill to arrest this until the arrival of the surgeon. I have twice hastened to such cases to find the patients dead of hemorrhage. It is to be regretted that the instructions now being given to engineers, firemen, and the police are lacking in practicability; still they are, perhaps, better than no instructions.

Dr. Murdoch: Despite what has been said, I still adhere to the opinion that instructions in medicine and surgery imparted to the laity can not result in good. You say, "We don't want these men to know very much; all we desire is that they may know what to do in emergencies. We want them to arrest hemorrhages, to resuscitate the drowned and a few little things of that kind." The man who is always able to arrest hemorrhage is a great surgeon.

How many of us could arrest hemorrhage as was done by Dr. Smith, of New Orleans? He tied the brachial for aneurism, then the axillary, then the innominate. That was the "little thing" required to stop the hemorrhage. That was all he did. A man who could arrest hemorrhage under all circumstances would be the greatest surgeon on the globe. The man who is able to give proper "first aid" to the wounded must be a good surgeon. For this reason it is that the attempts to teach the ignorant to do this will frequently result in disaster.

Dr. Green: I congratulate Dr. Davis on the result of his case. The discussion that followed it seems quite complete, yet there is a desire on the part of the public, when an individual is wounded, to arrest hemorrhage whether there is any hemorrhage or not. If an individual working in any of our mills is wounded, the first thing done by the bystanders is to "stop the bleeding." If the public could be taught to wait until the wounded individual would bleed, and then interfere, I think it would be a good step in the instruction of the laity. I have sent a number of patients to the hospital from the mills in the neighborhood in which I practice, and very frequently I have sent them without any application whatever. I remember two instances, in each of which an arm was torn off at the shoulder. Dr. C. B. King will remember one case, and Dr. Murdoch will remember the other. I think he amputated the arm. The soft parts were torn off almost completely at the shoulder and the bone two or three inches below, yet there was no bleeding.

Dr. Davis: In reply to Dr. Buchanan, I believe that until very recently, there is no authority for cutting through gangrenous parts. I do not know whether there were any bugs in the lymphatic system of this patient's arm or not. I am not much on bugs. I believe it was the hot water and the bichloride. The tissues were full of gas, and the cutting pressed the bubbles of gas out, but whether there were any bugs in them or not I don't know.

Dr. Batten: I have a case which illustrates the result of instructions to the laity. We all know that the laity know the use of bromide of potash, chlorate of potash, quinine, etc., about as well as physicians do, and are constantly going to the drug store for these drugs. If the patient has sore throat, the physician says: "Well, take a little chlorate of potash." If the trouble is want of appetite, they say to the patient that they will give him a little quinine, or a little bromide of potash if he has the headache. The consequence is that the laity, when they have the least thing the matter with them, take to

the drug store and procure those different drugs. I believe it results in harm. The case which I wish to relate is one in which a barber prescribed. He succeeded in salivating, but not in benefiting, a patient with syphilis.

Dr. J. J. Buchanan read the following paper on Unusual Result of Long-standing Tarsal Caries:

The patient whose case I am about to report, a girl of sixteen years, came under my care in June last, with the following history: Family record free from tubercular or specific disease, health perfect till close of third year, when a bleb appeared over the outer aspect of the os calcis, which subsequently broke down and formed the extremity of a sinus leading to the bone. This sinus remained open for years, occasionally discharging detritus of carious bone, till eventually the posterior portion of the calcaneum was entirely gone. Sinuses then formed in other parts of the ankle and lower part of the leg. During these thirteen years her health has been precarious, severe illnesses alternating with periods of comparative health. Some weight could be placed upon the toes till about five years ago, since which time the limb has been perfectly helpless, and its great weight has made it much of a burden. For some length of time she has been obliged to walk on crutches, and the weight of the limb permitted almost no walking outside the house. She has long been unable to move any of the toes or her ankle in the slightest degree.

When I first saw her her nutrition was fair, pulse ninety to one hundred, and temperature normal. The limb from the knee down was enormously enlarged, and at the calf was thicker than at any part of the thigh. It had the shape precisely of a limb the subject of elephantiasis; the skin, however, was comparatively normal, a little thickened and glazed about the ankle. A number of sinuses opened about the ankle and lower part of the leg, all of which apparently led to the astragalus. The condition of the foot precluded the idea of any conservative operation, the only question being whether to

amputate through the leg or at the knee. I amputated about the middle of the leg by antero-posterior flaps, using antiseptic precautions. The muscular tissue at the point of section had entirely disappeared and had been replaced by connective tissue. The flaps cut like salt pork, very heavy, inelastic, and were made up entirely of connective tissue with gaping vessels transversing it, and imbedded in it an occasional tendon. A single sinus in one of the flaps required scraping with the sharp spoon. The bones gave evidence of chronic inflammation. The larger vessels were secured by passing under them a needle armed with catgut, and tying them *en masse*.

Subsequent dissection of the amputated part showed its soft tissues to be in exactly the same condition as existed above; careful search failed to reveal a remnant of muscular fiber in the foot. There was complete disorganization of the ankle-joint, absence of the posterior portion of the calcaneum and beginning disease of the tibia.

The stump healed by primary union, and the patient was out of bed on the ninth day. Five months later her attending physician, Dr. Cyrus McConnell, wrote me that the remaining part of the leg had diminished to about the size of its mate, and that her restoration to health had been complete.

As to the pathological condition existing here, I suppose that during these thirteen years of inflammation and caries of the tarsus, there had been a constantly increased supply of blood sent to the foot, and that this had caused the enormous overgrowth of the connective tissue of the limb. Dr. John H. Packard, to whom I related this case, suggested that probably there was also an involvement of the lymph channels as in the so-called elephantiasis. I report this case for the reason that I have no knowledge of any similar one, and the literature at my command does not describe this pathological condition as resulting from carious disease.

Dr. Davis: I rise to speak of the fact only that I think in my experience I have seen a case very similar to Dr. Buchanan's. It was

a case of caries of tibia of long standing in a young woman. I cut down on it and scraped and worked around it in the manner of bone-scrapers, without hope of doing her much good. The tissues struck me as being in just the condition that the doctor describes. The part did not heal kindly, and after some weeks the limb was amputated above the knee by my colleague, Dr. Dickson. The description of the tissue makes the two cases very similar.

Dr. Allen then made some remarks upon sympathetic ophthalmia. The fact that there is nothing in the whole domain of medicine more important than the saving of the remaining eye to the man who has already lost one, will justify the time I shall consume upon the subject. I will not go into a lengthy discussion of the cause of this affection; some men believe that the germ of suppuration travels from the affected eye through the optic nerve to the sound one; some explain it through the sympathy of the ciliary nerves: whatever the cause, the point I wish to emphasize is the early removal of the injured ball. "Save the eyeball" is a too frequent cry in cases of injury even after the sight is destroyed. It is a cry that is ominous to the patient. Whether there is a foreign body in the ball or not (a matter which can not always be determined), whenever the sight has been destroyed and there is any irritation in the sound eye, early and complete enucleation is the best treatment. The injuries that in my experience are most frequently followed by sympathetic ophthalmia are those through the junction of the cornea and sclerotica, involving the ciliary body. When such an injury exists a sharp watch should be kept for the advent of sympathetic inflammation, and upon its appearance immediate removal of the wounded ball is indicated.

SIR ASTLEY COOPER'S ideal of a physician's wife: "She should be like roast lamb—tender and sweet, and nicely dressed, with plenty of fixings, but with no sauce."

## Reviews and Bibliography.

**The Best Surgical Dressing.** How to Prepare It, and How to Use It; with a consideration of Beach's Principle of Bullet-wound Treatment. By OTIS K. NEWELL, M. D., of Harvard Medical School. 179 pp. Boston: Cupples & Shord. 1888.

This neat little volume is mainly a translation of a paper by Dr. Johann Mikulitz on the uses of iodoform, to which is added an explanation of Beach's treatment of gunshot wounds. When the article of Mikulitz was written, in 1882, there might have been need of its translation, but at this time, when iodoform is not only in use by surgeons everywhere but also in the hands of the laity in most places, any thing further said in its favor seems superfluous.

Not so, however, with Beach's principle of treating wounds. One maxim in it is worth much more than the cost of the book, that is, never disturb a bullet wound unless there are positive indications of the necessity of so doing. A bullet entering the body in the usual manner is as harmless as a tooth-filling, and soon becomes encysted. It will scarcely be allowed that the discovery was made by Beach, but it is valuable none the less. The habit that brevet surgeons have of worrying and injuring their patients for their own curiosity and the entertainment of bystanders, can not be too severely condemned.

D. T. S.

**Prof. Ultzmann's Lectures on Diseases of the Urinary Organs.** Compiled by Dr. J. H. BRIK, Assistant at the Vienna Polyclinic, No. 1. (Brectenstein IX, Walhringerstrosse, Vienna.)

This little pamphlet, the first of a series, contains in a condensed form Ultzmann's Treatises on Cloudy Urine, Bacteria, True and False Albuminuria, Peptonuria, Hematuria, and Diagnosis and Treatment of Catarrh of the Bladder—all included in forty pages, yet pregnant with information and practical to a degree to suit the most exacting. From his table on the chemical and heat tests applied to cloudy urines, one can tell in the quickest way to what the cloudiness is due. When due to pus, the

localization of the inflammation, whether from the anterior or posterior urethra, or from the prostate, bladder or kidney, is determined by symptoms and methods more or less absolute, which are given concisely and clearly.

True and false albuminuria contains the three best tests, and various hints in using them are very useful and often not sufficiently observed.

In that portion devoted to hematuria we fear the condensation is at the expense of clearness. In the therapy of hematuria, Ultzmann recommends extract of ergot in two and one half grain doses every three hours as the best internal remedy. After the bladder is emptied local applications of nitrate of silver, one fifth per cent, or sesquichloride of iron, one tenth per cent; one half per cent of which are recommended. The treatment of catarrh of the bladder is given *in extenso*; altogether, the little book is well worthy of the perusal of the specialist as well as the general practitioner.

D. T. S.

**L'Ensergnement et l'Organization de l'Art Dentaire in the United States.** Report addressed to the Minister of Public Instruction, by Dr. KUHN. 299 pp. Paris: Octave Doin. 1888.

This work embraces the observations made by Dr. Kuhn, who was sent by the French Government to this country at the time of the International Congress to study the state of dental teaching and practice in the United States. The report makes a very favorable showing for American dentistry, it being the author's opinion that the American method of teaching is much better calculated to make good dentists than that of France.

D. T. S.

**Legons de Gynecologie Operatoire.** Par NULLIET, Professeur a la Fourlli de Medicene de Geneve, et LUTAUD, de Paris, with one hundred and eighty illustrations. 448 pp. Paris: J. Bailliere et Fils. 1889.

This work, which is by two among the most eminent of the gynecologists of France, is devoted to gynecological operations. In the preface the

authors urge the great advantages to students and their modification of Schultze's manikin for the practice and study of operations on the female genitals. These manikins are arranged for the use of such parts of the pelvic contents as it is desirable to operate upon, these being placed within the manikin. The work is well written, especially the chapters on the treatment of sterility in the female.

The authors have in preparation an atlas of gynecological operations, which will soon be issued.

D. T. S.

## Correspondence.

### LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

The annual exhibition of the toys, collected by the editor of *Truth* for distribution to poor children this year, eclipsed in variety and splendor all previous exhibitions. Some idea of its size may be gathered from the fact that there are some 22,000 toys, and each child in the London hospitals, work-houses, work-house schools, and infirmaries duly received a Christmas gift. Of these 22,000 toys 3,854 were dolls, dressed in every conceivable fashion. The home-made toys constituted a specially important feature and numbered some hundred more; there was a model switchback which worked capitally.

In a paper read at Guy's Hospital on Hospital Extravagance, Mr. P. Michelli, Secretary of the Seamen's Hospital Society, said much waste occurred under the heading of medical sundries and extras, and in the domestic department much more could be done to curtail expenses. With regard to indirect extravagance, the cost of collection, printing, stationery, commission, and advertising ate up half the money and only the balance was placed to the credit of the charity. All new hospitals he thought should be licensed by the Local Government Board or by the newly constituted county councils. Dr. Steele (comptroller of Guy's) expressed the belief that all hospitals prided themselves on their economy. The better

the patients were nursed and doctored the more costly was their treatment, and the public chiefly had regard to the treatment which the patient met with in making their contributions. He condemned the iniquitous taxation which had been imposed upon them. Guy's Hospital paid £1,400 a year for maintaining its own sick and St. Thomas' Hospital paid £2,000 a year in taxes.

Since Dr. Mulheson read a short paper upon the cure of stammering, at a recent meeting of the British Medical Association at Glasgow, he has had two hundred cases through his hands, and he is certain that his views upon the troublesome complaint are correct. He believes that the principal causes of stammering are the following diseases: chronic rhinitis and obstruction of the nasal cavities, chronic pharyngitis, and adenoid growth in the nasal pharynx or behind the soft palate. These diseases, according to Dr. Mulheson, will account for eighty per cent of the cases of stammering that are met with. This he has proved to be the case in his own experience. The other cases may be caused by diphtheria and other debilitating fevers. His story of how he hit upon his discovery is as follows: Several patients, ranging from the age of seven to twenty, who consulted him for deafness, were also the subjects of stammering and stuttering. With regard to this condition he adopted the usual means and remedies for the removal and treatment of ear mischief. In some of the cases it became necessary, in order to affect a cure, to reduce the irritation and the enlarged condition of the middle and superior turbinated bodies, and to remove adenoid vegetations from the naso-pharyngeal cavities. On their return visits two or three of these patients surprised Dr. Mulheson by informing him that not only were the ear symptoms relieved and hearing improved, but that they themselves and their friends noticed that the stammering and stuttering had decreased, and that speech had become almost uninterupted. These facts aroused his interest, and he began to pay special attention to such cases of stammering and stuttering as

he could meet with, inquiring carefully into their clinical history and the condition of the nose and the naso-pharynx. His investigation fully bore out the theory at which he had arrived, namely, that there exists a close and intimate connection in the relation of cause and effect between diseases of the nose and the cavity behind the soft palate and stammering and stuttering and other impediments of speech; in short, that this painful condition is another of the reflexes due to disease of the breath-way.

At the recent meeting of the Medical Society of London, Mr. J. H. Morgan showed an interesting case of a child with arrested development of the arm. The child was born at full term. The scapula was of normal size, but at the apex of the spine was a deep furrow of skin attaching it at this point to the bone. There was a shortened humerus articulating normally with the glenoid cavity. The fore-arm was also very short, in which the two bones were represented joined to this rudimentary humerus; the whole extremity was covered by healthy skin with excessive amount of subcutaneous fat. The hand was represented by four digits. The thumb was present, but occupied the position of the index finger, and the remaining digits represented apparently the second, third, and fourth respectively. The index was absent. The child was in other respects perfectly healthy and well formed. There was a history of fright of the mother during pregnancy, but Mr. Morgan attached no importance to that statement.

Mr. Morgan, during the past summer, operated upon a man, aged nineteen, who four years ago received a compound comminuted fracture of the skull two inches above the external angular process of the right parietal bone. He was not unconscious after the accident, but reached home on foot and became so, and remained insensible for three or four weeks. Several small pieces of bone were removed by the surgeon, and fifteen others came away in the discharges. Shortly after regaining consciousness he had his first fit, others occurred

at frequent intervals, becoming gradually more frequent until in the past year there had been one or two daily, and before the operation he had ten and twelve fits daily. The attacks lasted from a few seconds to two or more minutes. There was no aura, and he was not always unconscious; sometimes there was foaming at the mouth. The patient did not bite his tongue or pass urine. The optic disks were normal. The operation consisted in removing an irregular quadrilateral of bone and an almost equal expanse of dura mater together with the cicatrix of dura mater and adherent portion of the brain. The wound healed perfectly. There was no recurrence of the fits for three weeks, when they came on again and had continued, but less severe and less frequent than before.

This year the Liverpool Hospital Saturday and Sunday collection amounted to £9,344, about £400 more than last year. The Birmingham Musical Festival produced £2,500, which was given to the Birmingham General Hospital.

An album of bacteria, photographed by an Austrian army surgeon, was shown to His Royal Highness, the Prince of Wales, on the occasion of his recent visit to Vienna. This album, which contains a number of representations of pathological bacteria and micro-cocci, was exhibited at the international exhibition of amateur photographers held in that city during the autumn.

An ingenious individual has discovered that the average man, during his seventy years, consumes eighty tons of food, liquid and solid.

Sir William Jenner is stated to be suffering from debility, and has been ordered perfect rest for some weeks.

There are at present one hundred and fourteen female medical students in Paris, eight of whom are English.

LONDON, Dec., 1888.

ACCORDING to the decision of Internal Revenue Commissioner Miller, artificially colored butter is liable to the same tax as oleomargarine—two cents a pound.

## Translations.

UNDER THE CHARGE OF I. N. BLOOM, A. B., M. D., DERMATOLOGIST TO LOUISVILLE CITY HOSPITAL, ETC.

ON SOME PECULIAR EFFECTS OF CIRCUMCISION.—(*Deutsche Med. Zeit.*, Oct. 8, 1888. *Revue Med. de la Suisse Romaine*.) Professor Reverdin was forcibly impressed by a brochure of an American colleague who claimed that circumcision was indicated in bed-wetting, and that it often relieves patients of coxalgia. After trying it he gives his experience. A boy nine years old, and well developed, complained for several weeks of severe pain in the right hip, and walked lame. On examination in the upright position nothing abnormal was found; when he walked the mobility of the affected limb was diminished. If force was used in moving the leg severe pains were felt and the muscles were strongly contracted. The pains radiated toward the iliac fossa, the upper part of the thigh, and the inside of the arms. Measurement gave no definite results. The case seemed to be one of beginning hip-joint disease. R. ordered rest and extension. In spite of this treatment, for about half a year, there was no improvement, there was no swelling or sign of supuration, no difference in measurement, but the same functional disturbance and severe pain. At the last examination the great length and narrowness of the prepuce was noticed although the patient had never had any symptoms referable to that, nevertheless circumcision was performed and all the above-mentioned symptoms disappeared as if "before the wand of a magician."

Another case was still more strange and inexplicable. A young man became morose, melancholy, apathetic, and showed a decided suicidal tendency. His disposition changed completely and satisfactorily after circumcision. Reverdin does not pretend to explain the causal connection between the psychological change and the operation, although he says there was nothing in the patient's external relations to bring about the result. Fleury published similar cases of the cure of hysteria and hypochondria

by circumcision. In the practice of Prof. J. L. Reverdin, his cousin, were the notes of two cases when epileptic convulsions were permanently cured by the removal of a long, narrow prepuce.

A CASE OF EARLY MENSTRUATION.—(*Internat. Klin. Rundschau*, Sept. 30, 1888.) Dr. Dramant, of Vienna, reports the following case from his own practice: A. J., daughter of a frame manufacturer, was born in Hungary on the 27th of March, 1882; she is well nourished, strong, excellent complexion, with infantile expression of face. The arms are delicate and thin while the loins, glutei, and thighs are as well developed as is usual in full grown women. The breasts, too, are fully developed while the mons veneris and axillae are quite thickly covered with hair an inch or so in length. In 1886, the little girl weighed fifty-nine pounds, but now tips the scales at seventy-nine. Menstruation began in February, 1884, that is, before she was quite two years old, and continued regularly, occurring between the 15th and 17th of every month. When she had completed her first year all her teeth had appeared. In intelligence, speech, and actions, she was as other children of her age, but her voice was a peculiar deep bass. Her mother menstruated for the first time when sixteen years old. None of her relations menstruated before that time.

Menstruation continued in this case until the child was six years old. Since January 14, 1888, she ceased to menstruate, and since then, at the period of menstruation, the child has epileptiform attacks which come on at night during sleep. The child begins to gnash her teeth, the eyes are fixed and stony, and cyanosis, dyspnea, unconsciousness, convulsive movements of the extremities, trembling, and bloody froth at the mouth appear in quick succession. The attack lasts from one half to three fourths of an hour, and after it violent headaches, fatigue, and depression are complained of. At first only one attack occurred, but gradually the number increases every month.

OBSTETRICS AND GYNECOLOGY.—(By E. S. McKee, M. D., Cincinnati.) Embryotomy with Tarnier's embryotome was the subject discussed in a recent clinic by Budin (*Le Progrès Médical*). Budin prefers Tarnier's instrument as less dangerous to the maternal tissues than others. It is essentially a hook carrying a sheathed-like saw which is gradually tightened after the instrument is placed in position. He gives an intra-uterine douche of 1-2,000 bichloride solution after the operation. The case which he discussed made an uninterrupted recovery.

An unusual case of eclampsia is reported by Charpentier. (*Bulletins de la Société Obstétricale*.) Eclampsia came on suddenly at night, followed by a condition of partial coma, which persisted for forty-eight hours before the treatment had effect. The urine was extremely rich in albumen. Coma was followed by convulsions, in the first of which the fetus perished. Temperature and pulse were normal. Epigastric pain and headache were present, but disturbances of vision did not develop till forty-eight hours after albuminuria and convulsions had ceased. Labor was unattended by convulsions.

Pleurisy as a complication of ovarian cyst was discussed by Demons at a meeting of the Paris Société de Chirurgie. (*Annales de Gynecologie et Obstétrique*.) He had observed this complication as often as in nine out of fifty cases. The pleuritic effusion may be either unilateral or bilateral. Although they usually accompany large cysts, in some instances the latter may be small. In the discussion which followed, Terrier said that he had often noticed the association of pleurisy and ovarian cyst. He always punctured the pleural cavity before performing laparotomy when there was extreme dyspnea. Bouilly believed the complication rare, as he had only noticed it twice in twenty-five or thirty cases. Champonière thought that pleural effusion, or more properly hydrothorax, was most frequently associated with proliferous cysts with or without resulting ascites; the prognosis was always grave. The daily amount of urine and the quantity of urea are considerably

diminished. Terrillon had discovered pleuritic effusion in only three out of one hundred and twenty cases of ovarian cyst, and has always examined the thorax carefully. Verneuil said that any abdominal tumor connected with one of the pelvic or abdominal viscera might be complicated with pleuritic effusion. Potain had shown that a similar effusion might result from congestion of the ovaries and peri-ovarian tissues, from reflex irritation and hyperemia. It might be on the same side of the affected ovary, or on the opposite side.

The largest vesical calculus removed from a woman by dilating the urethra was done by Pozzi, of Paris. (*Le Bulletin Médical*.) The calculus was one and one half inches in diameter, which exceeds the record; the largest one removed in this manner before being one and three sixteenths inches in diameter. Although the operation is soon over, chloroform is necessary, as it not only does away with the pain, but also paralyzes the muscular fibers about the parts and allows a return of activity afterward. The subsequent exploration of the finger brings to light any calculus which may not have been detected by the sound. It is also a good method of diagnosis. The only precaution necessary is the antiseptic douching afterward and the retention of tubes to facilitate irrigation. The operation of Pozzi required about ten minutes, and was done by six hard gum-elastic bougies.

Apostoli's method of treating various gynecological complaints has made much progress, owing to the patient, persistent scientific work for which the distinguished author is so well noted. One of the most important events in this line was the paper on Some Novelties in my Treatment of Uterine Fibroids, with Answers to Objections, by Dr. Apostoli, read before the British Medical Association at Glasgow and published extensively on both sides of the Atlantic. The author thinks we have in electricity a most powerful means of safely treating fibroid tumors, and that it will in the future be felt a duty by the surgeon to make use of it before adopting other meas-

ures. He thinks, if others carry out his method as he has directed, they will reap the same new and interesting results it has been his good fortune to witness. To the general practitioner the method of Apostoli offers an efficient substitute for the knife, which they have so generally feared, in cases of fibroid tumors. In the treatment of endometritis the curette is being supplanted by the galvanic current. The great objection to the use of Apostoli's method is the first cost of the apparatus; another is the technical knowledge required; and yet another, the demand on the patience of both physician and subject. The method is truly that of specialists, and the condemnation of every bungler who undertakes it, and fails, should not be heeded. Though one may with very little knowledge of electricity effect cures, yet it is advisable to be well posted in electro-therapeutics before undertaking to manage currents of such intensities as are now being employed.

Uterine hemorrhage from a fibroid tumor checked by dilatation of the uterus is the subject of a report by Sanante in *Nouvelle Archives de Obstetrique et de Gynecologie*. A laminaria tent was introduced into the uterus, followed subsequently by two others. The cavity was then washed by a sublimate solution 1-1,000, and the hemorrhage and pain ceased immediately. Two weeks later menstruation occurred and was free from pain and normal in quantity. Irrigations were made from time to time and the symptoms did not recur.

Vaginismus is treated by Girard (*Journal de Medicine de Paris*) as follows: First, bromide of potassium in two-gram doses daily, then friction on the dorso-lumbar region with a liniment composed of sixty grams of the oil of hyosciamus and fifteen grams of chloroform. When the vaginismus is accompanied by fissure in the vulva add to the foregoing treatment the use of suppositories of krameria, composed of cocoa butter three grains, extract of krameria two grains.

Cauterization v. Curretting in the treatment of endometritis was the subject of a recent discussion at the Paris Obstetrical

Society. (*Bulletin et Memoires*) Pajot had cauterized the uterus for endometritis for forty years without a fatal result. He had four cases of parametritis which might be referred to this application. He attributed his freedom from accidents to strict antiseptic precautions. Charpentier preferred curretting to the *porte caustique* because of the greater rapidity of the cure and the absence of pain and inflammatory complications. Doléris warmly defended the curette, as with it the tissues could be removed and examined microscopically, and there was no danger of cicatricial contraction and less of peri-uterine inflammation.

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### Abstracts and Selections.

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SOME RECENT CONTRIBUTIONS TO OTOTOLOGY AND RHINOLOGY.—By J. M. Ray, M. D. Dr. E. J. Mouse (*Journal of Laryngology and Rhinology*, Vol. II, No. 2) presents a most interesting study of atrophic coryza or so-called essential ozena. By this term he says we understand an affection of the nasal fossæ non-ulcerative, and characterized by enlargement of its cavities and accumulation of secretions, possessing a fetid and characteristic odor. Of the many theories advanced to explain the origin of this most obstinate affection, he considers the following: (1) Zaufal's theory, that it is due to an excessive enlargement of the nasal cavities from congenital smallness of the inferior turbinated bones. (2) Fraenkel's theory, that it is a result or hypertrophy of the mucous membrane over the turbinated bones which ended in atrophy. (3) Michel's theory, that it is due to disease of the accessory cavities, especially the ethmoidal and sphenoidal sinuses. (4) Rouge's theory, that it is a disease of the nasal bones, and (5) Lowenberg's theory, that it is due to a micro-organism.

After a thorough discussion of the evidence in favor of each of these theories the authors conclude that, save the theory of Lowenberg, they are all insufficient to explain the phenomena of the disease. In modern text-books, and by most authorities in this country, the theory of Fraenkel has been accepted. The reporter can recall in recent years only one writer (Mulhall) in this country who has taken issue with the theory so ably advocated by the Berlin specialist. He ends the discussion of the pathology by stating that the secretion must contain some micro-organism, whether diplo-

coccus or other, which would produce decomposition in the secreted liquid. As to the etiology the cause may be due to diathetic influences. Of these, scrofula plays the most important rôle. The reporter indorses the following: Syphilis has also been incriminated, but this gives rise to a special ozena, which differs absolutely from the affection under consideration. His directions as to treatment agree with those in vogue among most specialists. The first indication is to get rid of the bad odor. This can be done by complete removal of the mucosities which accumulate in the cavity. For this purpose he prefers the nasal douche. At first he prescribes an irrigation of one (Oij) or two liters of tepid sulphurous water, to which is added two to four teaspoonfuls of soda bicarb., potas. chlor., marine salt, etc. This is followed by irrigation with a tablespoonful of following to pint of tepid water:

Phenic acid.....	3v;
Glycerine.....	3iij-3i;
Alcohol 90° .....	3iss;
Water .....	3x.

The phenic acid may be replaced by chloral, resorcin, salicylic acid, etc. When the spray is used he employs the following:

Phenic acid.....	3ss;
Resorcin.....	gr xlv;
Glycerine ..	3iss;
Aqua.....	3ix-3iij.

M. in atomizer with small quantity of antiseptic vinegar.

He has had no effect from thymol, which has been recommended by others. He says of the use of galvano-cautery and scarification advocated by some, that they are useless mutilations which do not appear to me to be justified in practice. He concludes this most interesting paper by reference to the disease when present in young girls about the menstrual age. At this time the odor is most pronounced. The active treatment should be by solution nitrate of silver, together with tonic treatment and iodized oils.

*Asthma.* Dr. T. H. Bosworth (American Journal Medical Science, September) presents a most interesting paper based on an analysis of eighty cases, with especial reference to its relation to local diseases of the upper air tract. He says, from a review of the literature of the subject, one is struck with the vague and indefinite views which have prevailed in regard to this affection to comparatively recent times, and that it has been dealt with more as a symptom than as a disease. He reviews, in an interesting manner, the many theories advanced as to

the cause of the asthmatic paroxysm. From a study of which he says it all inclines itself to the subject of asthma as a reflex disease. Attention was first attracted to the nose as a factor in the production of certain attacks of asthma by Voltolini, who reported a case due to the existence of nasal polypi. Following this were a number of similar reports, in which asthma was traced not only to polypi but other nasal disorders. In the same line of study came the observations of Doly in reference to nasal disease and hay-fever. Up to this time hay-fever had been regarded as simply a periodical coryza or influenza, in which the paroxysms were characterized by the same symptoms as are met with in an ordinary cold in the head. As a matter of fact, however, acute rhinitis and an attack of hay-fever differ in a marked way in many respects. This was soon recognized, and a new name was given to hay-fever, *naso motor rhinitis*. A natural division of asthma can thus be made—hay asthma and perennial asthma. The question arises, how far is there any connection between these two affections? Dr. Bosworth believes that they are virtually one and the same disease. Hay asthma being a naso motor rhinitis; perennial asthma a naso motor bronchitis, the paroxysms being excited by favorable atmospheric conditions. The causes of hay-fever, he claims, depend on three conditions: (1) A neurotic habit, as shown by Beard. (2) The presence of pollen. (3) Disordered condition of nasal passages. Asthma also depends on three conditions: (1) Neurotic habit, as shown by Salter. (2) Disease of nasal mucous membrane. (3) Obsolete condition of atmosphere. He says "a large majority if not all cases of asthma are dependent upon some obstructive lesion in the nasal cavity." This is proven by the relief furnished by local applications of cocaine and by the permanent relief of so many cases by removal of the obstruction in the upper air-passages. During the last five years Dr. Bosworth has treated eighty cases of asthma. Of these, thirty-four were cases of hay asthma, forty-six perennial asthma. Twenty-nine of the cases of hay asthma and thirty-three of perennial asthma had nasal symptoms preceding the attacks. Thus, of eighty cases of asthma sixty-two were ushered in by sneezing and other nasal symptoms. Fifty-four gave a history of catarrhal trouble. Of the thirty-four cases of hay asthma, when examined as to the local condition in the nose, nine had hypertrophic rhinitis, twelve hypertrophic rhinitis and deflected septum, five polypi and deflected septum, four polypi, three deflected septum, one elongated uvula. Of the forty-six cases of perennial asthma thirteen had hypertrophic rhinitis,

eleven nasal polypi, eleven hypertrophic rhinitis and deflected septum, six polypi and deflected septum, three deflected septum, two adenitis and hypertrophic rhinitis. Thus showing that all of the eighty cases of asthma presented, when examined as to the condition in the nose, some obstructive lesion. The treatment carried out in the eighty cases was the use of caustic, the nasal septum saw, and the snare. The results of the treatment were, in the hay asthma, eighteen cured, fourteen improved, one unimproved, one unknown; perennial asthma, twenty-eight cured, twelve improved, two unimproved, four unknown. Dr. Bosworth is known as a most accomplished throat specialist, therefore the results he gives are matter of uncommon interest, and prove that the intranasal treatment of asthma is by far the most satisfactory method of controlling this distressing and heretofore intractable disease.

*The Surgical Treatment of Cerebral Abscess from Ear Disease.* Dr. Thomas Barr, in the presidential address before the Otological Section of the British Medical Association (British Medical Journal, September, 1888), discussing this important question, says: "By the specially brilliant work done in the operative treatment of intracranial conditions dependent upon disease of the ear, hopelessly fatal consequences of ear disease have recently been successfully dealt with, and purulent collections formed in the substance of the brain have been boldly cut down upon and the pus evacuated." Dr. Wm. Macewen, of Glasgow, has operated upon seven such cases, where by trephining and draining abscesses in the temporo-sphenoidal lobe he has saved five lives. Dr. Barr presented to the Section two of these cases. The first, a boy, ten and a half years of age, operated on January 22, 1887. Dr. Barr first perforated the mastoid and washed out the middle ear with an antiseptic solution. The symptoms, which consisted of vomiting, rigors, headache, and slow pulse, not being influenced by the opening of the mastoid, Dr. Macewen trephined the skull. A half-inch disk of bone was removed from the squamous portion of the temporal bone at a point an inch and a half above and half an inch behind the center of the external auditory meatus. A hollow needle was inserted into the brain, and after it had penetrated the brain tissue for about three quarters of an inch, there was a sudden escape of foul gas, followed by about two drams of offensive yellowish-colored pus, while shreds of sloughed brain tissue were removed by the forceps. A second aperture was drilled just above the meatus to secure drainage, and chicken bone tube inserted. The parts were dusted with boric acid and covered with sublimated wood-wool

pads. In six weeks the wound had healed. The second case was operated on in May, 1888. Man, twenty one years of age. Three weeks before the head symptoms began by headache, vomiting, slow and intermittent pulse, normal and subnormal temperature, contraction of left pupil, paresis of all the ocular muscles with exception of the external rectus, partial facial paralysis on opposite side, paresis of right arm, and wrist drop. The left mastoid was trephined, but no pus found. Dr. Macewen trephined the skull above the external auditory canal and pierced the brain tissue with a trochar. Three ounces of foul pus were removed. The cavity was syringed with a weak solution of carbolic acid and drainage established. The dressing was not removed for three weeks, when wound was found to be almost healed. Operations similar to these reported by Dr. Barr have been performed in England successfully by Borker Caird and Victor Horsely, and in this country we recall a case reported by Weir. Dr. Barr predicts that in the near future not only will it be possible to reach and drain abscesses in the temporo-sphenoidal lobe of the cerebrum, but it will also be possible to save life by opening into the cerebellar fossa, and removing pus from the neighborhood of the lateral sinus, or to open into and clean out thrombi from the interior of the lateral sinus by ligature and removal of a portion of the sinus.

**PELVIC HEMATOCELE: OPERATION BY LAPAROTOMY; SUTURE OF CYST TO ABDOMINAL WOUND; DRAINAGE; RECOVERY.**—This case is presented as a contribution to the surgical literature on the treatment of large pelvic hematoceles by abdominal incision and drainage. T. M., aged thirty-two, unmarried, entered the Massachusetts General Hospital, January 20, 1887. Family history negative. Catamenia every four weeks; flow normal in amount, lasting four days, accompanied by considerable pain on the first and fourth, with vomiting. Last unwell two weeks previous to entrance to hospital. No special sickness. For the past few weeks has been losing color, appetite, and strength. Complaints of dyspnea on exertion; bowels perfectly regular up to date. Felt as well as usual and worked all day yesterday. At 4.30 A. M. awakened from sound sleep by sudden, sharp abdominal pain, which was at first located in left iliac fossa, but soon shifted to the right side and back. At the same time obstinate bilious vomiting. Had small movement from the bowels two hours subsequent to the attack. This morning swelling appeared in the right iliac region, and has since been growing gradually. Pain steady up

to 12 M., requiring several subcutaneous injections of morphine. Since that time pain present in paroxysms, and there has been but little vomiting. No chill. Patient passed urine at 6 A. M. Since then required catheter twice.

*Examination.* Patient lies without difficulty, with legs extended, is anemic, poorly nourished; anxious expression, tongue moist with slight coat. Pulse 68, fairly strong. Heart: soft systolic souffle in pulmonic area. Abdomen: a circumscribed swelling, dull on percussion, markedly tender, in right iliac fossa, extending to pubes; abdomen elsewhere soft, resonant, not tender. *Per vaginam:* cervix movable, pointing downward and backward, not continuous, with swelling felt externally. *Per rectum:* marked tenderness in front and to the right, tumor felt anteriorly like cervix, extending not quite to middle line. Urine: normally acid, s. g. 1029. No albumen; sediment slight.

January 20th. Milk and lime-water and brandy ordered alternately every three hours. Poulitices to abdomen; deodorized tincture of opium, minims 15 to 20 *p. r. n.*

During afternoon of day of entrance she vomited every thing taken into stomach; morphine and poulitices gave much relief.

On the 21st of January pain was almost entirely controlled by numerous subcutaneous injections of morphine. Required to be catheterized every six hours; had chill at 2 P. M. No vomiting.

Examination of the tumor showed increased size, extending two inches to the left of the middle line. No fluctuation, marked tenderness over whole of tumor. *Per vaginam:* general sense of pressure downward; body of uterus pushed over forward and to the left; temperature 99°, pulse fairly strong.

Peptonized milk was ordered, four ounces every hour, and enemata of the same every six hours. No marked change on the 22d or 23d, although morphine was required. No vomiting, but distinct fluctuation felt over the tumor, which remained of about the same size. (The foregoing is an abstract from the medical records of the hospital.)

On the 24th of January, the third day after entrance, I was asked to see the case in consultation, and advised transference to the surgical ward for immediate operation.

Operation under most careful antiseptic precautions. Ether given; an incision made in the right iliac region along the inner half of Poupart's ligament and about an inch above it. On opening the peritoneum there came at once into view a tumor evidently cystic, its walls being very dark colored and glistening. The cyst did not appear to be adherent, but its re-

lations were not thoroughly explored for fear of rupture of its walls, which appeared exceedingly tense. Using fine, round needles, and silk sutures, the cyst wall was stitched to the anterior parietal peritoneum in such a manner that the presenting portion of the cyst, about the size of a half dollar, was entirely shut off from the general peritoneal cavity. In this surface a free opening was made, and about three pints of dark, bloody fluid escaped. There were no clots. Exploration of the cyst discovered several flesh-like projections into its cavity feeling like clots; these were not disturbed. The edges of the wound of the cyst were stitched to the abdominal wound, and a large drainage-tube, reaching to the bottom of the cyst, was fastened in. The cavity was then thoroughly washed out with a hot solution of sulpho-naphthol.

The night following the operation there was slight pain which was relieved by one sixth grain of morphine. On the following morning patient was comfortable and the dressings were changed.

During the next three days the discharge was discolored; on the fourth day after the operation there was no blood in the discharge. There was some pus from the granulations of the wound, and all stitches were removed.

The subsequent progress of the case was without interruption and toward recovery, and ten weeks from the date of the operation she was discharged from the hospital, well.

Dr. Whitney's report of the examination of fluid is as follows:

Thin, bloody fluid, sp. gr. 1007, highly albuminous. No formed elements except blood corpuscles. Blood in large amount, but did not coagulate. Probably ascitic fluid with blood. *Charles B. Porter, M. D., Boston Medical and Surgical Journal.*

**A CASE OF COMPOUND COMMINUTED FRACTURE OF THE SKULL.**—April 10, 1888, H. W., twenty-nine years old, a brakeman, was struck by an overhead bridge. He was seen to fall from the car, and was found in a stupid and dazed condition, but not unconscious. He was brought to the Massachusetts General Hospital, where I saw him. There was a small transverse wound, half an inch long, just above the right superciliary ridge. The soft parts of the forehead and the eyelids were much swollen, so that no depression of the bone could be made out. There was crepitus over a considerable area, as if the bones were extensively comminuted.

The patient was dull, but answered questions coherently. He complained of severe pain in the head. The pupils could not be

seen because of the swelling of the lids. In an hour he had become somewhat more stupid, and there were occasional twitchings of the left side of the body.

The head was carefully shaved and scrubbed with ether and with corrosive sublimate solution. A transverse incision four inches long was made. On coming down to the surface of the bone it was found to be extensively comminuted. The fragments were in irregular positions — some depressed, others elevated.

It became necessary to extend the incision at right angles to the original incision. A considerable amount of the frontal bone was removed, including both frontal sinuses and the orbital ridge, with about half an inch of the orbital plate on the left side. Some of these pieces were overlapped by others, and more or less depressed. At one point the dura was perforated by a fragment, which, pushing through it, pressed open the cortex. There was some hemorrhage from this wound in the dura, which was controlled by a catgut ligature. The extremities of the incision were brought together by sutures, but the greater part of the wound was left open and packed with iodoform gauze.

The patient rallied slowly from the ether, and remained in an apparently comatose state for several hours. There was no return of the muscular twitchings, but he became violently delirious toward evening. On the following day he was better, but restless and delirious. The wound was dressed and was found perfectly healthy. In a few days there was some delirium. The wound healed rapidly. Ten days after the accident the patient had become quite rational, and gave a correct account of the accident, but was somewhat childish and inclined to somnolence. He continued to improve rapidly, and on June 2d the wound was entirely closed except a small granulating spot.

The hospital record of June 13th says: "No head symptoms whatever. Declares himself to feel as well as ever. Wound entirely healed. Extreme depression in the frontal region. The cicatrix pulsates slightly. Discharged."

There are several points of interest about this case:

First, the retention of consciousness after so severe an injury. Apparently there was no time at which the patient lost consciousness until the ether was administered.

This illustrates very forcibly the importance of not attempting to measure the extent and degree of a head injury by the subjective symptoms.

A second point of interest is the irregularity of position of the comminuted fragments. It seems probable that, from the number and po-

sition of the fragments, necrosis of some of them must have occurred, even if there had been no sloughing and suppuration of the soft parts.

Moreover, it seems probable that if the fragments had not been removed, and the bleeding from the wounded dura controlled, there would have been fatal pressure from blood clot.

If none of these had happened, the depressed fragments would certainly have produced subsequent brain irritation with its attendant miseries.

The lack of symptoms of paralysis was due, I think, to the fact that the motor area of the cortex was not injured or pressed up. It seems probable that the delirium which followed etherization was due, not to the operation, but to the concussion taking place at the time of injury.

Such an amount of the skull might be removed by trephining the uninjured bone, as in case of a brain tumor, but it is rare that so extensive a comminution of the bone by injury is followed by recovery.—*Dr. F. B. Harrington, Ibid.*

#### GONORRHEAL INFECTION OF THE MOUTH.

Dr. Condict W. Cutler reports a case of this kind in the New York Medical Journal. Miss J. C., twenty-one years old, presented herself for treatment at the New York Dispensary, July 18th, with the following history: Ten days previously, while under the influence of liquor, she yielded to the unnatural desires of a sailor, and had taken his penis several times into her mouth. The next morning her mouth felt raw and dry, and the saliva had a horrible taste. On the second day little sores made their appearance about the lips, and the condition of the mouth remained the same. On the third day the gums and tongue became swollen and painful, and on the fifth day the whole inside of the mouth was so intensely inflamed that she was unable to eat; and a whitish fluid, mixed with blood, having a nasty odor and taste, was secreted. This continued until the pain and inability to eat compelled her to seek medical advice at the dispensary. On examination, the lips were found cracked and covered with herpes in all stages of development. The mucous membrane of the lips and cheeks was thickened, reddened, denuded of epithelium in places; and in small areas covered with a false membrane, which was easily detached, leaving an excoriated surface.

The gums were swollen and retracted from the teeth, bleeding readily upon pressure. The tongue was swollen, very tender on touch and pressure, and could be but slightly pro-

truded, and then only with great pain and effort. The surface was red and glazed in appearance, with small superficial ulcers here and there, secreting a thick yellowish pus. The soft palate and anterior pillar of the fauces presented an inflamed appearance, but beyond the parts seemed to be in a normal condition. The breath was extremely offensive, although there was but little salivation. The secretion from the mouth consisted principally of mucus, pus-cells, and epithelium, and large numbers of bacteria. The false membrane contained micro-organisms resembling the gonococcus, but their identity was not established.

The sailor freely admitted that he had been suffering from a severe attack of gonorrhea, and, not wishing to infect the girl, had entreated her to comply with his unnatural demands. She had yielded to his wishes, and become affected with a purulent stomatitis, probably gonorrheal in character.

The symptoms were greatly relieved with the local application of glycerine and bismuth subnitrate, together with a mouth-wash of chlorate of potassium; but the patient disappeared from under observation before the cure was complete.—*Medical and Surgical Reporter.*

**BUTYL-CHLORAL IN TRIGEMINAL NEURALGIA.**—There are only a few remedies which exercise their action upon one nerve alone. According to Liebreich (*Therapeutische Monatshefte*) butyl-chloral is one of these; in doses from 15 to 45 grains it produces anesthesia of the trigeminal nerve. Liebreich has convinced himself of this in tic douloureux. Unfortunately it is not lasting in its effect, and large doses produce sleep. It is very serviceable, however, in neuralgia of the trigeminus in which the pain is not chronic. Rheumatic face-ache, pains occasioned by injury, tooth-ache, either from an inflammation of the pulp or from periostitis, may be obviated by the use of butyl-chloral. He has used butyl-chloral with much satisfaction also in cases in which at the beginning the filling of a tooth has exerted painful pressure.

The drug is disagreeable in taste and difficultly soluble. The following prescription for its use is suggested:

Butyl-chloral.....gr. xxx-lxxv;  
Spiritus vini rectificat. ... ℥i;  
Glycerini.... .....fʒv;  
Aqua destil.....fʒiii ʒvi.

M. Sig: Take three or four tablespoonfuls at once.

The size of the dose is to be regulated by the intensity of the pain and by the condition of each individual patient.—*Wiener Med. Presse.*

**GUAIACOL.**—Guaiacol is a highly refractive, colorless liquid, with an aromatic smell, slightly soluble in water, readily so in alcohol and fixed oils. The statements made by Sommerbrodt and Fraenkel as to the benefits derived from the administration of creosote in phthisis led Sahli to try guaiacol, which has advantages over creosote in that it is of definite composition, and has a less unpleasant taste and odor. Sahli prescribed it thus:

Guaiacol puriss.....℥xv to ℥xxx;  
Aq. destil.....ʒvj;  
Sp. vin. rect.....ʒvj.

A teaspoonful to a tablespoonful two to three times a day, after food, in some water.

The solution should be kept in a colored bottle, as exposure to light causes the deposition of a resinous substance.

Sahli likewise administered the guaiacol in cod-liver oil. He found it to improve the appetite, loosen and diminish expectoration, besides ameliorating general discomfort and relieving pain.

Schüller caused his phthisical patients to inhale the vapor of a watery solution of guaiacol, and gave, in addition, extract of guaiacum-wood in pills. He states that his patients improved under this treatment.

Fraentzel (*Deutsch. Med. Woch.*, 1888, No. 7, p. 138) has used guaiacol in more than a dozen cases. He considers it the active constituent of creosote, and recommends the following formula:

Guaiacol.....ʒiijs;  
Tr. gent.....ʒj;  
Sp. vin. rect.....ʒviij;  
Vin. Xerici.....q. s. ad Oj.

One tablespoonful two to three times daily, in a wineglassful of water. He strongly advocates its use.

Horner says he has employed guaiacol for four years at the General Hospital at Zwickau in the treatment of tuberculosis. He gives it in pills containing about three fourths of a minim, commencing with one thrice daily after food, and gradually increasing the number of pills to ten in a day. Under this treatment, combined with careful diet and hygienic precautions, he thinks he has seen complete cure of cases of phthisis when not far advanced, and improvement even in those of long standing. In many cases the appetite improves, the bacilli decrease, the cough and fever and expectoration diminish; night-sweats disappear, and the patients improve in strength. In some cases no distinct effect follows, but the drug never produces any untoward results. Most patients take it very well, and only a few object to it.—*Therapeutic Gazette.*

# The American Practitioner and News

"NEO TENTI PENNÂ."

Vol. VII. SATURDAY, JANUARY 19, 1889. No 2.

D. W. YANDELL, M. D., )  
H. A. COTTELL, M. D., ) - - - Editors.

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## THE LEGAL RIGHT TO A DEAD BODY.

A question recently brought before one of the English courts led to the first clear and explicit decision as to who may have the legal possession of a dead body. The question came up on the suit of a lady against the executors of a testator for money expended in the cremation of testator's body.

The court decided that whoever is responsible for the burial of the body is the executor, *prima facie*, and must bury the deceased in a manner suitable to the estate that he leaves behind him.

The decision also reaffirmed the principle that there is no property in a dead body, and that no man can dispose of his body by will. The only way, therefore, in which a testator can, if at all, compel obedience to his wishes in the matter of the disposing of his body, is to make the fulfillment of his wishes the object of a trust or the condition of a gift.

Controversies sometimes spring up between coroners and the relatives of those found dead, with money about their person, as to the expenses of burial. This is especially likely to occur in cases of persons found drowned in rivers.

As the amount which a coroner may charge for a burial is usually fixed by law, it is some-

times insisted that he should expend no more than he would be allowed for burying a pauper. Undoubtedly the courts would approve the course of a coroner in every such case in acting upon the presumption that the body found was that of a citizen worthy of such burial as a person in good station in life merited. Where bodies are assigned under certain conditions to colleges for scientific purposes, it is presumable that they would then be regarded as invested with the character of property.

## SIR MORELL MACKENZIE.

This eminent specialist seems to have jumped out of the frying-pan into the fire. His recent voluminous denunciation of his associates in the case of the late German Emperor has put him beyond the pale of forgiveness with the profession of Germany, and now, at home, the profession and the press are outvicing each other in doing him slight or dishonor.

The Royal College of Physicians has put him under its august censure, while his recent lecture in Edinburgh was not only ignored by the doctors of that place, but treated as if it had not been by the London Lancet. This arbiter of English professional fate makes no mention of the lecture, even in its columns devoted to intelligence from Scotland.

Fortunately for Sir Morell he has a sufficiency of wealth and patronage to enable him to crook his finger at the boycotters; and if the present ordeal shall purge him of his conceit, and teach him the unwisdom of airing his supposed personal grievances in sensational publications, himself and the guild will be the gainers by it.

## DEATH OF DR. WM. R. SPALDING.

On the 12th of December, Dr. William Roscoe Spalding, of Austin, Texas, died of typhoid fever at the Louisville City Hospital, where he was serving a term as resident graduate. Dr. Spalding graduated at the University of Louisville in March, 1888, with the highest honors of the class. Even during his first course he carried off a prize which was open for contest to students of the first,

second, and third years. But it was not as student, eminent as he was in this regard, that Dr. Spalding shone brightest. It was rather in the integrity and purity of his character, and his perfect gentlemanly deportment. It would doubtless be borne witness to by every one who enjoyed his society, that during the whole time he spent in this city he was never known to speak a word that his best friend could have wished unsaid.

Notwithstanding the large number of honors he won in the course of his studies, his manner was so unassuming that envy and jealousy were disarmed, and his competitors to a man were pleased to see the honors awarded him.

Dr. Spalding was a young man who did honor to his parentage, his *alma mater*, and his State.

His early loss is a grievous disappointment to a wide circle of hopeful and devoted friends.

### Notes and Queries.

ABSOLUTE SIGNS OF DEATH.—There is something so appalling, even to the strongest mind and the bravest heart, in the idea of being buried alive, that so long as such a thing is possible there will be a continuous debate on the topic in all circles of the educated community. Dr. Richardson's essay differed from what has usually been said on the matter in the fact that it enumerated, from a long experience, the circumstances under which the practitioner may be called to determine whether or not life is extinct, as well as described the immediate tests that ought to be brought into play in order to prove that death is absolute. No less than ten distinct circumstances were assigned as being advanced by relatives of deceased persons on the question of suspended life, to which was added the expressed wish or direction of a person during his or her own life that a skilled examination should be carried out after assumed death, in order to prevent the possibility of interment while yet a spark of life should remain. With most of these circumstances calling for in-

quiry the profession is more or less familiar, but two were specified that are not generally recognized—namely, simulated death from narcotism caused by chloral, and the same simulation from what the author designated traumatic catalepsy, and the cataleptic insensibility from the shock of an electric discharge, or from lightning stroke, or from concussion. Two cases were cited illustrative of these conditions, both of which might be rendered in the text-books as new additions to the list of doubtful evidences of actual dissolution. Of the many tests or proofs of death enumerated by the author, there are also two that should be recorded not only as new, but as being exceedingly simple and at the same time strictly physiological in character. The first of these, which has originated with the reader of the paper, and which Sir William MacCormac, the president, commented on so favorably, is the wrist test, or that of putting a splint on the fore part of the wrist so as not to impede any current of blood which may be making its way through the radial and ulnar arteries, and then tying a fillet firmly round the wrist so as to compress the veins firmly on the back of the wrist. If the veins of the hand, under this test, show no sign of filling, the absence of any vital circulation may be declared certain; while, if they fill, the fact of a certain "low pressure" circulation may be assumed to be present, and therewith an indication of merely suspended life. The second test, new probably to most readers, is that to which the name of Montiverdi was attached as its discoverer, and which is called the ammonia-hypodermic test. In using this test the operator injects one hypodermic syringeful of strong solution of ammonia under the skin of the arm or some other convenient portion of the body. If the body be not dead, if there be the faintest circulation, the ammonia will produce on the skin, over the point where it was injected, a bright-red patch, on the surface of which raised red spots will appear; but if there be absolute death, there will be produced a brown dark blotch, which is definitely conclusive against

any possible vitality. One addendum to the indication of putrefaction as a proof of death is also worthy of note. Putrefaction may be delayed by two causes: by coldness of the surrounding air, and by the introduction into the body before death of an antiseptic substance like alcohol; or by a combination of these two causes. In such instances it is the proper practice to force on, so to speak, the putrefactive change by raising the temperature of the room in which the body lies to summer heat, and by adding moisture to the air. This proceeding plays a double function; it affords the body the best chance of restoration if by chance the life is not extinct; and it gives the strongest evidence of death in the quick putrefaction it excites if death has veritably occurred.—*London Lancet*.

*Editors American Practitioner and News:*

From time to time, through the columns of the Practitioner and News, and more elaborately in the New York Medical Journal, I have endeavored to inculcate a new theory as to the cause of the great preponderance of head presentations at the time of delivery.

This I attributed to two factors, one of which has been taken into consideration by previous writers, while the other is, I believe, original with myself.

I have contended that head presentations are the result of swimming movements on the part of the fetus coupled with the influence of the conical form of the lower segment of the uterus. The motion of the legs alone, when a human being is in water, produce diving movements; and a fetus using mostly the legs *in utero* dives head foremost down to the outlet and is retained there in the cone of the lower segment. On the other hand the natural walking motions of quadrupeds produce swimming movements, and the quadruped *in utero* swims upward to the outlet.

Clearly an explanation to be satisfactory should embrace all cases found in the same category. An explanation that accounts for head presentations in the human race

should also account for head presentations, which are just as constant, in lower animals. Now what I wish to ask of the readers of the Practitioner and News is, that they will kindly report such observations on presentation in lower animals as may have come to their knowledge. Not only is it desirable to have reports of presentation at birth, but also the relative positions of fetuses of any kind of animals whatever *in utero* where this can be ascertained. Also the position of the head of young birds in the egg and any other facts bearing on presentation. The aim is to learn whether polarity may have any thing to do with determining the character of presentation.

Very respectfully, D. T. SMITH, M. D.

943 WALNUT STREET, LOUISVILLE.

**SULPHUR FUMES IN DISINFECTION OF VESSELS.**—The amount of sulphur dioxide required for the proper fumigation of the holds of vessels, and the best means of obtaining it, have been subjects of recent letters to the Surgeon-General of the Marine Hospital Service by Passed Assistant Surgeon H. R. Carter and Assistant Surgeon J. J. Kinyoun. (Weekly Abst. Sanitary Rep.)

A larger percentage of  $\text{SO}_2$  than is obtained by the ordinary pot or open-furnace method is necessary. Dr. Carter says: "It would seem that the most perfect combustion (of the oxygen, I mean, for the sulphur is in excess) would be accomplished by a hot blast forced through tuyères (or a pipe perforated with small holes might do better), through molten sulphur, or projected with some force on the surface of molten sulphur."

Dr. Kinyoun states that air containing 10 per cent of  $\text{SO}_2$  proved germicidal to all spore-producing microorganisms that he experimented upon, the time of exposure being between twenty-four and ninety-six hours, but that  $\text{SO}_2$  in any strength had failed to kill the spores of anthrax.

Dr. Kinyoun erected an experimental furnace for the evolution of  $\text{SO}_2$  upon the principle of a reverberatory furnace. The furnace was rectangular, the perpendicular be-

ing about three times greater than the horizontal diameter. Three sides were of brick, the fourth was a closely fitting iron door. The inside consisted of a series of shelves, one above the other, for holding the pans of burning sulphur. The shelves were made insufficient at their right and left sides alternately, thus leaving air spaces and causing a column of air, which was forced in by means of bellows at the bottom, to pass over each shelf with its pan of burning sulphur before reaching the space above.

The top was provided with a pipe for conveying off the gas and an aspirator for measuring its percentage. Repeated experiments gave from 14 to 16 per cent of  $\text{SO}_2$  at a temperature of  $21^\circ \text{C}$ ., while ordinary burning of sulphur in a closed space at the same temperature gave only 6 per cent.

The principle brought out in the above experiment is to be practically used in the construction of the new disinfecting vessel which is being constructed for the Marine Hospital Service at Chandeleur Island.—*Journal American Medical Association.*

**NOVEL CASE OF DROWNING.**—It is reported that a man well under the influence of alcoholic liquor recently went into a saloon in Trenton, N. J., and called for a glass of beer, which was given him on a table at which he was seated. He was soon observed to be leaning forward upon the table as if in a sleep or stupor. "When the bar-keeper tried to arouse him, half an hour later, it was found that he was dead, his nose being immersed in the liquor in such a way that respiration was completely stopped." Many cases have been reported of persons having been drowned in but little depth of water, but this is the first case reported of a man drowning himself in a glass of beer.—*Ibid.*

**DR. AGNEW'S RETIREMENT.**—The medical students of the University of Pennsylvania will present to Dr. D. Hayes Agnew an oil portrait of himself on his retirement from the professorship which he has held for several years in the institution.

J. W. LAMBERT, the well-known inventor and manufacturer of listerine, died at his home in St. Louis on the 4th inst., at the early age of thirty-six years. He was a genial gentleman and one of the most progressive business men of the day.

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### SPECIAL NOTICES.

**MEDICAL BOOKS AND JOURNALS.**—The remarkable catalogue of medical books and journals issued by Dr. A. E. Foote, of 1225 Belmont Avenue, Philadelphia, has the same relation to the ordinary commercial catalogue as the Index Catalogue of the Library of the Surgeon-General's Office does to the ordinary catalogues. It is now being issued, being complete as to hygiene, yellow and other fevers; obstetrics, surgery, anatomy, practice, urinary, venereal, brain, and nerve, etc. When fully completed it will include over 14,000 titles. This remarkable catalogue is sent free to every physician requesting it on headed paper, or by including his professional card. It is indispensable to any practitioner who thinks or writes. This is undoubtedly the largest stock in the world. He issues similarly complete catalogues on chemistry, physics, and geology, and on all other branches of science. A natural taste for mineralogy has led Prof. Foote to accumulate the largest stock of minerals in the world, over one hundred tons, these he sells at the ridiculously low price of \$5 and \$10 per hundred good specimens, carefully labeled, and one hundred labeled crystals for \$1. Price list sent free.

**DR. ESGUIVE**, colonization physician to the Paris-Lyons-Mediterranean Railway, Bon-Medja, France, March 28, 1887, says: I tried bromidia (Battle) on two cases of insomnia, which I had already treated for some time, with a mixture of equal parts of bromide of potassium and chloral. I noticed that hypnotic results were produced with much smaller doses of bromidia than of the mixture of bromide and chloral. In a large number of cases it is important not to push too far the quantity of bromide of potassium. On this account I believe bromidia is destined to be of real value, particularly in insomnia of cardiac origin, and I deem it vastly superior to the simple mixture of bromide of potassium and chloral.

THE solubility of coated pills is a matter of very great importance to the physician who may desire to prescribe those of quinine and other medicines offensive to the taste and smell. Various experiments from the different sources have demonstrated the fact that sugar-coated pills prepared by William R. Warner & Co. are the most soluble and reliable in this respect. Those containing quinine are made of good material and full strength, as demonstrated by chemical analysis. These facts were established by Leroy M. Yale, M. D., of New York, and A. B. Lyons, Analytical Chemist, Detroit, and others. And the well-known reputation of the house is a sufficient guarantee. *Southern Medical Record.*

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÂ."

VOL. VII.

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No. 3

[NEW SERIES.]

*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.*—RUSKIN.

## Original Articles.

### CHRONIC CYSTITIS IN WOMEN.\*

BY W. SYMINGTON BROWN, M. D.

After ages of careful dissection, clinical examination, surgical operations, and conjoint study, it is really astonishing how little we know about the anatomy of the pelvis and its contents. Soon after my text-book on Diseases of Women was published, I received several letters and reviews criticising the drawings which illustrate the female genital organs as not true to nature. To which criticism I reply: My dear sir, I know that. No mere drawing or model can be true to nature any more than the alphabet can be eloquent. A drawing to be useful, must be a diagram; and that requires a brain behind it in order to be useful. One might as well find fault with Dr. Auzoux's manikin because the layers are hard and stiff instead of soft and flexible. A photograph, however well executed, only represents one phase of the human face—at rest—a phase non-existent during life, and scarcely possible even after death. We should not demand too much from pictures.

These reflections occurred to me while studying the shape and position of the bladder in women. That organ is almost as movable as the uterus. We are told in books that its transverse is greater than its vertical diameter; but I suspect that the proportions must be reversed when it holds a gallon

of urine, as it sometimes does. Then, again, we are told, and told truly, that highly concentrated urine irritates the bladder, and that the irritation may even end in cystitis. But it is not so generally known that "hysterical" urine of low specific gravity, almost destitute of saline ingredients, is also a common cause of irritation and pain.

Acute cystitis is a very rare affection in women: some authors say that it never occurs, except as a sequence of traumatic injuries. At one time many physicians believed that cystitis resulted from using forceps in labor; and I have no doubt that this erroneous belief acted as a bugbear to curtail the employment of that useful instrument. In our day very few competent practitioners refrain from using forceps on this account. The probability is that cystitis more frequently results from long-protracted labors which should have been shortened by applying forceps or turning.

I have only seen one case of acute cystitis in a woman (apparently caused by swallowing tincture of cantharides to induce abortion), and that case may have been due to other suspected agencies. I have also seen three cases in men, during our civil war, resulting from gunshot wounds in that region.

Unfortunately, chronic cystitis is far from being a rare affection in women. Many of the cases occur after tedious labors; some follow innocent attacks of gonorrhea; a few are caused by errors in diet, such as highly spiced food, fermented liquors, gum chewing, etc.; but in my opinion the larger number result from not emptying the bladder often enough. A false modesty and a genuine lack of opportunity combine to bring about this disastrous effect.

\*Read before the Gynecological Society of Boston, December 14, 1888.

It is a curious fact in the history of modern civilization that, with all our pretensions to gallantry, so little has been done in large cities to accommodate women in this respect. Some one has asserted that the amount of soap used in a nation is a fair test of the advance it has made in civilization. I would respectfully suggest, as an additional gauge, the number of public urinals for women and men.

When cystitis has lasted for years, the mucous membrane of the bladder may become detached in shreds, and the inflammation spread to the muscular and even to the serous coats. In most cases of long standing the organ is contracted to one half, or even less, of its normal capacity. The mouths of one or both ureters become thickened and congested, sometimes occluded; and the urine undergoes changes incidental to decomposition. Small quantities of blood, pus, and mucus frequently appear in it; and instead of the normal acidity, it is voided in an alkaline condition.

Under these circumstances it is possible, and even probable, that the inflammation may progress upward, affecting the ureters, and, finally, one or both kidneys. And it often happens that the cystitis excites a reflex pain in neighboring organs; sometimes in parts at a considerable distance from the original seat of inflammation.

The treatment essentially consists in affording the bladder as much rest as possible, and in other ways allaying the inflammation. But to give rest to an organ constantly in use, night and day, must prove a somewhat difficult task. It has been recently ascertained that part of the intestinal mucous membrane excretes urica, and that a portion of the kidneys' work may be performed by the intestine. Perhaps this explains why saline laxatives often alleviate the pain attending cystitis. Dr. Skene, of Brooklyn, L. I., relates a case where a lady patient "had a catarrh of the bladder of some months' standing, which I had been treating in the usual way with only slight benefit. She was one day attacked with cholera morbus, with serous purging and

vomiting. The effect for a time was to almost suspend the action of the kidneys. When she recovered she was delighted to find that her cystitis had left her."

Quite recently I have had a case of my own somewhat similar. Mine occurred in a married man with a severe gonorrhea, who was seized with typhoid fever, and after the usual watery stools for two days the urethritis abated, and the consequent discharge entirely stopped. He took the iodide of phenol mixture every four hours; but I do not imagine that that had any thing to do with the cure of his gonorrhea, which had only been running about a week. I attribute this reflex cure to the diarrhea.

Chronic cystitis furnishes no exception to the general rule that each case should be studied separately, and the treatment modified according to individual peculiarities. Idiosyncrasies, in fact, seem to affect the bladder even more than other organs; and in women more than in men age must be taken into account. Before puberty, during the child-bearing period, and after the menopause, constitute eras during which bladder affections essentially differ. The following interesting (personal) case belongs to the last-mentioned period.

I first visited Mrs. Blank, at her home in Lynnfield, Mass., December 26, 1887. She is a married lady, about sixty-three years of age, with a grown-up family, who has always enjoyed good health until 1884, when she began to suffer pain in the bladder, accompanied with frequent calls to urinate, night and day. During the whole three years she has never been able to retain her urine for more than an hour at a time, and sometimes she was obliged to use the vessel every half hour or so.

Mrs. B. had been under the care of several physicians, regular and irregular. Although naturally of a placid, happy disposition, her face showed marks of suffering and anxiety. Pulse 85; temperature 99.5°. Her urine, drawn by a soft catheter, contained pus, mucus, and crystals of the triple phosphates. There was no uterine or ovarian disease.

At my second visit, a small caruncle, growing at the lower edge of the meatus urinarius, was removed by means of a wire snare, and the raw surface painted with iodide phenol. A similar but smaller growth was found at the neck of the bladder. After swabbing the urethra with a solution of cocaine, this was cauterized in the following manner: The lower third of an English gum catheter (No. 7.) was cut off, stuffed with a morsel of surgeon's cotton at the distal end, saturated with Lugol's solution, and fitted with a wooden piston. This greased catheter was passed through the urethra until the oval opening was opposite the growth; then the piston was pressed backward, and the solution applied to the growth exclusively.

For a period of six weeks she took a tablespoonful of the following solution every four hours during the day; and also used it as an injection into the bladder every night and morning. Infusion of buchu was used as a drink *ad libitum*:

Benzoic acid. ....	3ij ;
Biborate soda....	3iv ;
Distilled water.....	3vi. M.

Afterward, during the treatment, it was taken twice a day. I found that she had refrained from drinking water as much as possible, under the mistaken notion that it would aggravate her sufferings. She was told to drink water, or its equivalent, freely, in small quantity at a time. She took lithia water for several weeks with apparent benefit. All kinds of fermented liquor were absolutely forbidden.

Her diet was carefully regulated. Salt meat, salt fish, pork, lobsters, beans, highly spiced soups, fried food, and pastry were prohibited. In addition to her regular meals, she was instructed to take a small cupful of hot milk or gruel at bedtime. She relished Mrs. Lincoln's potato soup in a modified form, a recipe I can heartily recommend in such cases.\* The common practice of

soaking beefsteak with butter was interdicted. The usual directions were given to overcome constipation, namely, a regular hour daily; massage in the track of the ascending, transverse, and descending colon; oatmeal porridge at breakfast, and occasionally a small dose of phosphate soda in water.

Attention was paid to position in bed, by raising the pelvis with graded cushions, so as to avoid contact of the urine with the *trigonum vesicæ*, the most sensitive spot in the bladder. During the first two weeks she remained most of the time in bed, to secure the benefit of rest. Within three weeks the pain had much abated, and also the frequent desire to urinate. At the end of six weeks the urine was free from pus and triple phosphates, and it could be retained about two hours.

After one month's treatment, I only visited her weekly; and in May, 1888, she considered herself cured. The injections were administered by her daughter occasionally till the following August.

As the bladder had become much contracted, I made an attempt, toward the close of the treatment, to dilate it by means of tepid salt water from a fountain syringe, beginning with three ounces, and continuing these injections twice a day until the bladder could hold about a pint. After a few trials this process was intrusted to the patient's daughter, who faithfully carried out my directions. Dilatation should be effected very gradually. There is some risk of paralysis; and it seems possible, when the ureters are abnormally dilated, that the kidneys themselves may be injured.

This brief report would not be complete if I failed to call attention to the potent efficacy of hygienic, comfortable surroundings, admirable nursing, and a cheerful frame of mind on the part of the patient. At my first visit she remarked that her patience was almost exhausted; but I found a good stock still remaining, and a feeling of ra-

tional contentment which greatly assisted her physician in the subsequent treatment. Unreliable patients, whose words can not be depended upon, constitute one of the severest trials we are subjected to.

When we meet with a thoroughly honest patient, who intelligently follows our direction, half the battle is fought, and we know what we are about. On our part, I think that it is the physician's duty to explain his orders as well as he can, and so enlist her valuable co-operation.

STONEHAM, MASS.

### INSANITY.\*

BY H. K. PUSEY, M. D.

*Member of Medico-Legal Society of New York, and Formerly Superintendent of Central Kentucky Lunatic Asylum.*

It was Clouston, I believe, who said that "no prudent man on the witness stand would allow himself drawn into an effort to define insanity." Every writer on the subject has endeavored to frame a definition that would cover a sufficient number of cases to meet the demands of the medical and legal professions. That none have yet succeeded in this general way is no argument against the possibility of defining each individual case with sufficient accuracy to meet the demands of humanity and justice.

It is an easy matter to frame a definition that meets the popular idea of the unreasonable, incoherent, and crazy conduct of the acute maniac or the mental helplessness of the terminal dement; but when it comes to differentiating between the acts that result from eccentricity and depravity and those resulting from disease of the brain and the nervous system that only carry the patient beyond the border-line, then many difficulties present themselves. The amount of mental disease that dominates the conduct of a vicious and a bad man may not carry the good man beyond the bounds of propriety. Acts that constitute insane conduct in one person may be no evidence of insanity in another person. Every case must be decided upon its individual presentation and from the changes that the habits

and the conduct of the individual have undergone, though in many instances these changes may have been only exaggerations of what was previously wickedness and depravity.

There exists in the mind of the legal profession and of some medical men very crude ideas upon this subject. I heard an expert witness for the Commonwealth, in a recent criminal prosecution in this State, say that the unnatural, incoherent, and unreasonable actions detailed by the witnesses for the defense, as having characterized the conduct of the prisoner for his entire life-time, raised in his mind no question as to the sanity of the accused; because, as long as was the catalogue of his so-called insane acts, there had been no act recounted that he (the witness) had not seen as the result of eccentricity, depravity or alcoholic intoxication—leaving the logical conclusion that an act to be an insane act must be an act that could not have been performed by a sane man, by a depraved man, or by a drunken man.

This doctor's views on the subject were only a slight exaggeration of the ideas of insanity entertained by the legal profession, which are extremely narrow, and relate exclusively to the acts of the individual who, to be insane, must be entirely *non compos mentis* and in every way irresponsible.

In spite of this exacting view of the subject the course of the law is beset with its difficulties. No law-making power in any country has ever undertaken to enact a statute defining responsibility or irresponsibility. It has always been found necessary to leave the law to be defined by the courts on the presentation of each individual case, precisely as insanity is defined and diagnosed by the physician; consequently the rulings of the courts are as varied and conflicting as have been the efforts of medical writers to frame a satisfactory definition of insanity.

The medical man, from a therapeutical as well as a physiological standpoint, takes a much broader view and finds responsibility and irresponsibility existing in the same individual, and sanity and insanity, soundness and unsoundness, existing in the same mind, as healthy and diseased tissues may be found in the

\* Read before the Louisville Medico-Chirurgical Society, January 4, 1889.

same organ, each tissue performing healthy or diseased function, or suspended function, as the case may be. The physician deals with insanity upon these principles, and assumes it as the prerogative of his profession to determine the presence or absence of disease without regard to the opinion of those who deal with it as only a moral and legal question.

The foregoing facts are recognized by all authors in their attempts to define and classify the insanities. Regarding the brain as an aggregation of organs or nerve centers that preside distinctively over the functions of life, the anatomist and physiologist have undertaken to classify the insanity according to the part of the brain affected, or according to what is known as the physiological functions of the part.

But the classification that is perhaps most approved is based on the four divisions of the mind, and looks to a distinct disorder of each of these divisions without the involving of the others. Thus, we have perceptual insanities, intellectual insanities, emotional insanities, and volitional insanities. These divisions of the mind, however, are so interdependent on each other and upon a healthy cerebration throughout that we may rarely have disorder enough in one to carry the individual beyond the range of accountability without some effect on the others. Therefore, all insanities may be considered more or less compound, that is, involving more than one division of the mind, or more than one of the brain-centers, but not necessarily all of them, and in many instances not to the extent of obscuring the distinctive features that serve to classify it.

Illusions and hallucinations resulting from disorder of any of the perceptions must be corrected by the intellect, else they are insane illusions and insane hallucinations; any defect in the intellect or interruption between the perceptive centers and the cerebral cortex that leaves illusions and hallucinations uncorrected constitutes perceptual insanity and controls the conduct of the individual. It is not improbable, either, that illusions and hallucinations may be so strong as often to deceive the normal intellect, and through emotional or volitional impulse lead to irresponsible acts.

The emotions are reached through the perception and the intellect, and any excesses of either exaltation or depression that are not corrected or controlled by the intellect constitute emotional insanity. Strong emotional impulses may be controlled and restrained by the intellect aided by the will, and other equally strong impulses may not be obeyed for want of will power to execute them.

I have at this time under treatment two gentlemen whose cases illustrate both phases of this trouble. Each is about thirty years old, and both are engaged in clerical pursuits. Both are conducting their business accurately, one with great care and caution in order to conceal his infirmity, and the other is doing his work apparently automatically without any desire or will on the subject.

One of these cases I alluded to at the last meeting of this Society. He is suffering from cerebral congestions that recur at irregular intervals and are doubtless the result of inherited nervous impressibility. These attacks are attended with strong homicidal and suicidal impulses. He says that while he is passionately in love with his wife and child and with life itself, and he has no delusions of persecution by the world, or gloomy forebodings as to success in business, on each recurrence of the bad feelings in his head he experiences such impulses to suicide and to homicide, including his wife and child, as to alarm him with the fear that an impulse may come which he will not be able to resist, and hence he applies for treatment.

The other patient is an unmarried man. The brain is anemic, the feelings are greatly depressed, he is indifferent to life and says he would have suicided before this time if he could have determined just how to accomplish the end. There seems to be a complete paralysis of the emotional centers. He says he can feel no love for or gratitude to the best friends he has in the world, to those upon whom he has been dependent for kindly attentions in sickness and at whose hands he has received nothing but the kindest of treatment. He seems to feel no remorse for his ingratitude nor resentment toward others of his friends who have neglected and avoided him.

The intellect in both these men seems to be intact, and both would be considered legally sane and responsible; yet one has not become a homicide and a suicide because he has been able, by the aid of his intellect and the power of his will, to resist emotional impulses that come with such force as to make him doubtful of his ability to continue to successfully resist them in the future; and the other man has not suicided because he had not enough will power to select the mode of making away with himself, or to carry it into execution if he had determined upon the mode.

From a medical standpoint both these men are insane, and would be so regarded by every one as far as related to medical treatment; yet neither of them could be committed to an asylum or deprived of any liberty or right except upon his own testimony, or possibly upon the facts confided to me as his medical adviser.

Intellectual insanities result in delusions or false conceptions which are not incompatible with accurate knowledge on all subjects to which the delusions do not relate, and all acts of the individual not prompted by these delusions may be sane and responsible acts. Intellectual insanities are also attended with morbid impulses, both of a subjective and objective character, and due allowance must be made for these.

Intellectual impulses resulting from delusions are not always morbid in the sense that they are irresistible or even unreasonable. Delusions may lead to acts that are insane only because the perceptions are deranged. Hallucinations and illusions of sight and sound that present to the mind the appearance of danger to person, property, or character may be as real as normal perceptions, and the resultant acts of self-preservation and protection may be reasonable and of the same character that prudence and self-respect would suggest to the sane mind. Hence, the fallibility of the "knowledge test" and the "knowledge-of-right-and-wrong" test of insanity, as also the "power-to-resist" test. The intellect being deceived by the perceptions, the will unsuspectingly obeys the dictates of the ideas; so that both the intellect and the will

may innocently consent to a violent and unlawful deed that is solely the result of insane perceptions.

Rulings of court that are confined to the intellectual and volitional faculties fail to recognize the perceptions and emotions as divisions of the mind, or else it is assumed that the parts of the brain employed in their functionation are not susceptible of disease.

Most of the conscious impulses of the will, both normal and abnormal are dictated by the perceptions, ideas, and emotions; and the will responds with equal readiness, whether these impressions come from a healthy source or as hallucinations, delusions, and morbid impulses from disease.

The will thus being the executive agency of the mind and subject too, within itself, to overpowering impulses, both of a conscious and an unconscious character, volitional impulse becomes the most interesting form of insanity—especially when it is considered that the will not only carries into execution the morbid impulses of the other faculties of the mind, but in its own impulses may turn defiantly upon these other faculties and, in spite of the ideas and wishes of the subject himself, or without ideas or wishes, he is prompted to violent and motiveless deeds, in many instances with the full knowledge that the deeds are wrong and with a conscious desire to do them because they are wrong, and because the sufferer wants to do something that is vicious and bad.

The will is a complex faculty and often plays fantastic pranks with its victims. Its disorders throw many obstacles in the way of the medical jurist. That sudden volitional impulses do arise without premonition, and disappear on the commission of the most horrible deeds that are as unavoidable as fate itself, is not questioned by many writers. It is fortunate, however, for justice and humanity that such cases are rare, and that it is possible in most instances to discover them either by the absence of motive or in premonitions of longer or shorter duration before the culminating phenomenon shall occur.

It is only by undertaking to analyze the perceptions, the true and the false, and the

conceptions, the true and the false, and the emotions and volitions with their morbid impulses, singly or combined, that we can appreciate the difficulty in the way of establishing any single test of sanity or insanity, or of fixing any rule by which it may be defined in general terms. The failure to recognize this fact and the want of courage to admit it, except by well-informed alienists, has led to much ignorant and profitless discussion on this subject, and to apparent antagonisms between the medical and legal professions as well as to much blundering in the administration of justice.

As before stated, no difficulty is found in defining and diagnosing insanity according to the legal idea of it, but the physician who deals with it as a disease discovers many shades of mental aberration that never reach a judicial tribunal.

It is only in defining cases that are not up to the legal idea of insanity that the physician is called upon to aid the court—generally with a view of limitation and control of individual actions, or for the protection of property rights, or more frequently to determine responsibility or culpability in criminal prosecutions. In all such cases the physician should confine himself to a description, as far as he can, of any diseased condition that may exist, and to the effect that it would probably have on the mind, leaving the question of responsibility to be determined by the court and the jury.

The question of mental responsibility, at best, can be only imperfectly met. In the organic structures it is not always possible by aid of chemistry or physiology or even by the microscope to determine where health ceases or disease begins, or where functional activities will cease to support life. The will or free agency of man on which responsibility depends is not the product of any substance that can be thus examined or demonstrated, but it is the result alone of functional activities, the relations of which to each other we know as little of as we do of the operations of the mind itself, nor is the relation that mental symptoms sustain to the extent of the brain lesion by any means fixed and uniform.

For these reasons the prudent physician should be content to leave the matter with the court, for whose errors, if errors be committed, he will not be responsible; and for these reasons, too, any departure from mental health ought to be considered in extenuation of punishment for crime, especially in commutation of the death penalty.

A man should not always be acquitted of crime or have his acts invalidated because he is insane. Insanity as a plea applies only to acts that result from disease of the brain or consequent delusions and morbid impulses, while the individual having other faculties of the mind apparently unaffected is responsible for other acts and may do many responsible things. But in view of the difficulties that surround this subject and the impossibility of knowing the extent to which the different departments of the mind are dependent upon each other, or the precise relation that the functional activities of the brain and nervous system sustain to each other in the process of mentation, it will always be safe to give the mentally diseased or defective the benefit of any doubt in determining the degree of punishment by keeping them where the errors of human judgment could be corrected.

LOUISVILLE.

## Societies.

### LOUISVILLE SURGICAL SOCIETY.

Stated Meeting January 7, 1889, Vice-President  
Dr. J. M. Mathews in the chair.

The essay of the evening was by Dr. J. M. Mathews; subject, Diseases of the Anus.

In substance he said: There are many books which treat of diseases of the rectum, and yet one half of the diseases that the surgeon is called upon to treat in this region are diseases of the anus, and not of the rectum proper. It is to the consideration of some of these that I call attention. They are a distinct class of diseases. Some of the most painful and some of the most dangerous diseases that affect this part of the economy are diseases of the anus and not of the rectum.

As regards the treatment, it is absolutely necessary to make a distinction, and yet we find, in reading the books of numerous authors, there is not that distinction drawn between diseases of the anus and those of the rectum that should be.

The first that I would mention is anal fissure rather than fissure of the rectum.

Recently I saw in one of the journals an article entitled "A New Treatment of Rectal Fissures." It stated that local applications of one part of chloral to fifty parts of water, touching the fissure once or twice a day, then filling into the fissure a piece of greased cotton, and repeating the measure four or five times, would effect a cure. I say this is misleading, from the fact that if a man has rectal fissure no local application can be made.

Recently a gentleman came into my office, stating that he had a fissure of the anus. On examining him I found he had a rectal fissure. I told him that I could cure him absolutely by an operation; that in four or five days he might return to his business. He said he would not submit to an operation; that if I could not cure him by local applications he would not take my treatment. I declined the case. I met him months afterward; he had been under treatment from the day he was in my office. I asked him how he was getting along; he said better, but not cured. If by opening the verge of the anus we can see the fissure just embracing the fibers of the sphincter muscle and not running up into the rectum, the disease can be cured absolutely by such applications as the author of the article quoted recommends; but if the fissure be one within the sphincter muscle, running up into the rectum, beginning sometimes at a point too high to be seen, with all the characteristic symptoms, especially the agonizing pain after defecation, it can not be cured without divulsion of the sphincter muscle. Moreover, an application to it would be quite as painful as divulsion. Anal fissures I treat by local applications, rectal fissures by divulsion of the sphincter.

The next class is anal ulceration. I find no mention of this disease in the books.

They treat of rectal ulceration, classifying it as malignant, non-malignant, and specific, but do not take into consideration the fact that the anus itself may be ulcerated, and when so is more painful than the rectum in like condition. The smallest ulceration that involves the anus proper is a very painful affection, and requires as absolute treatment as rectal ulceration.

Ulceration of the rectum is said to proceed from numerous causes, but anal ulceration is generally due to syphilis. Though commonly due to secondary syphilis, it is often found in the tertiary stage. Such ulceration can not be treated effectually without the internal administration of antisyphilitic remedies.

As to condyloma, I have never seen a case that was not syphilitic, though it is true we may at times cure condylomata without the internal use of antisyphilitic remedies. It is my habit to make an application of calomel and bismuth. A case recently came under my care in which this application, made daily, was followed by total disappearance of the growth in three or four weeks. Therefore, while I do not say that condyloma may not ulcerate, I hold it to be a very different thing from the form of syphilitic ulceration which destroys a portion of the tissue. I remember once to have seen a boy, a patient of Dr. Goodall, who had condylomata. The doctor questioned this boy as to syphilitic history, and could get none. He wrote a prescription consisting of mercury and iodide of potassium. I said to him, "Why do you do this when you have no history of syphilis at all?" His reply was, "I have seen so many cases where syphilis developed only in the rectum and nowhere else, that I take this to be a local manifestation of this disease, and therefore I give constitutional treatment to cure the local condition." This remark may have influenced me in the opinion that all these cases are of syphilitic origin.

The next disease I would mention is fistula in ano. The books describe rectal fistula. I want to speak explicitly on this point, because I have mooted the question with some eminent men. The writers

speak of "internal, external, and complete fistula of the rectum." I do not think that should be the order of things, because so many patients come to the surgeon with external fistula, and the probe is introduced in search for the internal opening. Now, some surgeons say it is absolutely necessary to find this internal opening that it may be embraced in the cut. Not long ago a surgeon from Versailles, Ky., brought a patient to me to complete a diagnosis, stating that he expected to operate, but that, after a search of three weeks, he could not find the internal opening, and therefore would not operate. I can not understand that this has any bearing upon the case at all. If the probe goes to the mucous membrane the search is complete. If it is pushed up as far as practicable, we have done all that can be expected of it. A fistula that admits of deep probing is properly a rectal fistula, but there are fistulas that cause a great deal of disturbance that are not rectal fistulas. A short time ago a man came into my office and said that he had been under the observation of a number of surgeons in another State for rectal trouble. He had been treated by local applications for a long time, and then they had advised him to go to Hot Springs, Ark. He had been there two or three months, but without relief. In searching for this trouble I found a sinus that was superficial just outside the anus, embracing only the true skin. I divided it and trimmed the edges in my office without anesthesia. I watched the case for some time, and all symptoms of anal trouble disappeared.

There is a class of troubles embraced under the head of fistulas which begin outside the rectum, say in the perineum, or laterally, or in front, and not running toward the bowel at all. I have known the mistake to be made, in introducing the probe into the opening, that the gut was pushed through and the tissues divided, leaving the fistula without being operated upon. We are all cognizant of the fact that external piles is a disease of the anus and not of the rectum. It is a question with some as to

what factors are involved in the production of external piles. We know that pregnancy by pressure produces this disease. An external pile is an anal affection, and not rectal. Those men who write about curing piles with one remedy certainly can not have in view this character of pile, and yet the distinction is not drawn sufficiently to enable the reader to know what the author refers to.

A gentleman in this city, upon whom I operated several weeks ago, told me that he had had piles for twenty years; that for fifteen years he had been compelled to ride in a buggy because walking hurt him, and even riding in a street car did him injury. In this case, as in many cases, I made no examination, but made an appointment to operate, expecting to find large protruding internal piles. An assistant administered the chloroform, and I divulsed the sphincter muscle. There were no internal piles at all. I never saw a smoother gut, but he had an anal trouble that I do not see mentioned in the books. When the sphincter was fully dilated, and the dilator taken out, the anus looked like a patulous os uteri. There was a hanging down of the true skin all around the anus to the extent of an inch, and yet on the inside it was perfectly smooth. Not a trace could be seen even of a small vein. There was no external pile according to the description of the books, and yet this man had a trouble which had given him annoyance for twenty years. It was nothing but a superfluous amount of skin around the anus, not involving the rectum at all. This became irritated by exercise, etc., and, I take it, might have become a little ulcerated, exciting that condition of pain and inconvenience which would lead a man to think he had piles.

I once saw a lady, who had a similar condition, claiming to have had piles for fifteen years. A gentleman in Jeffersonville had the same condition, and my record-book will show other cases of the kind.

Now it is a question, what should be done with these patients that have suffered for years under the supposition that they have

piles? They have no rectal trouble; the anus only is involved.

In each of these cases I put the patient under an anesthetic and removed all the superfluous skin. I once heard a distinguished rectal specialist say that the more cutting one did around a person's anus who had piles, the better for the patients. I go upon that idea. When I cut all the skin off I apply ligatures, because some vessels are cut during the operation from which there may be hemorrhage afterward. Therefore I take the forceps and pull the skin out in four and sometimes five different sections, and make a sweep around it with a curved bistoury until I get nearly under it, then I throw a silk thread around it and cut it off; and so on through the sections until I have a perfectly smooth anus. Each of these patients has been entirely relieved of his sufferings.

#### DISCUSSION.

Dr. A. M. Cartledge: Do you make the line of incision at the junction of mucous membrane and skin?

Dr. Mathews: No, I never do that.

Dr. E. R. Palmer: I was told by a physician of Seymour, Ind., that in operations about the perineum he did not use antiseptics because of the known fact of the non-tendency of the structures of the perineum to suppurate. What is your experience? Do you get much suppuration?

Dr. Mathews: If I fail to take antiseptic precautions I do get suppuration.

Dr. H. H. Grant: What parts do you include under the term "anus"?

Dr. Mathews: The tissues outside of the sphincter muscle.

Dr. W. L. Rodman: I think most of if not all the points made by the speaker are very well taken. I have been struck, in reading the books on rectal and anal surgery, with the fact that they have never been explicit enough in their differentiation between anal fissure and fissure extending up into the rectum. I think there should be a difference in the treatment of the two conditions, and that they should be described as different affections.

I think, again, that Dr. Mathews makes a very good point in regard to rectal fistula, in that most if not all the authorities are against him, but I believe where there is a fistula leading down to the rectum, and one which one has every reason to believe has an internal opening, and yet after several examinations one fails to find it, that it is unwise surgery to ask the patient to go and come back again, that one may make two or three more trials before operating. If there be an internal opening, and you pass the probe sufficiently high, you can be almost certain that you are going to include it in your incision. If you do not, the inflammatory action which is set up is almost sure to close any internal opening. Several times, when I believed there was an internal opening (but could not find it), and when I would find the mucous membrane very much thinned, I have punched a hole through the rectum pretty high up and cut through the skin and tissues.

I am glad to hear a man of so much experience as Dr. Mathews make this statement. There is usually no more than one internal opening in fistula, and I believe one is justified in taking the chances of including it in his incision.

Dr. W. O. Roberts: Dr. Mathews' idea of what composes the anus and mine are entirely different. I believe, as is taught by the books, that the anus is that portion below the internal sphincter muscle.

As regards fissure, this disease must involve some of the sphincter muscle in order to be painful, and the amount of pain will depend greatly upon the location. If it is situated posteriorly, as in most cases, it is very much more painful than if anteriorly, and while I believe that the treatment in all cases where it involves not only the upper part of the sphincter but also the internal sphincter is by divulsion, yet in some where it is located anteriorly I think it might be relieved by local applications.

In regard to condylomata I agree with the essayist, that it is a syphilitic affection. At any rate, I have never seen a case of condyloma in this locality that did not oc-

cur in a syphilitic patient; and if it occurs in syphilitic patients, why not treat it with antisyphilitic remedies? I find no trouble in these cases in treating them with the powder mentioned, but I use in connection with it always antisyphilitic treatment, and also absorbent cotton kept between the folds of the buttocks to absorb moisture.

In regard to fistulas, I think in nearly all cases they are anal, and not rectal. The books lay down the distinction between marginal and deep fistulas.

In the treatment of fistula in ano there is a very small amount of tissue to be divided, and I think this can always be done without anesthesia. In deeper fistulas it is very much easier to find the internal opening after divulsing the sphincter than before. I was struck with this fact upon seeing Mr. Allingham operate. He never operated upon fistula or any thing else about the anus or rectum without first fully divulsing the sphincter muscle. Since then I have always done this in connection with operations on fistula, and I have found that the internal opening was thereby much more readily detected. I must say that every time I have operated without finding the internal opening I have done so with the fear that I would not cure my case. I am glad to say, however, that experience has generally borne out the statement made by Dr. Mathews. We do sometimes, however, have horseshoe fistulas; and where this is the case a straight cut will not cure the disease.

As regards superfluous skin around the anus, I do not think there is any treatment but to take it off. If you do not take it off it will, through the patient's neglect of cleanliness, act as an irritant, and very frequently lead to the occurrence of marginal abscesses.

Dr. Ap Morgan Vance: Some time ago I operated upon a young girl for right angular deformity of the hip. The hip did very well. I had an idea at the time that it was the result of bone lesion from which a sinus led. I sent her to Dr. Mathews. He thought it might possibly be a rectal fistula.

Three weeks ago he assisted me in exploring it; we found that it was to all appearances an external fistula in ano, the opening being possibly three fourths of an inch from the verge of the anus, coming down from the bony sinus, and discharging into the ischio-rectal space. The operation was done here without finding the internal opening, the probe going up quite high. The operation resulted in bettering her condition. I do not believe it will cure the sinus coming from the hip, but it will limit the opening to the rectum so that the sphincter will control the pus, and she will evacuate it in her alvine discharges.

Where we have fistula in ano and can not find the internal opening, I do not see why division should not be done at first, since it would give one the same amount of light as divulsion.

Dr. W. Cheatham: Have you ever tried the galvanic cautery in these cases?

Dr. Mathews: No. I think there would be trouble in getting it completely through the fistulous track. If we could apply it to the bottom it would doubtless do well.

Dr. Grant: It seems to me that the differences which Dr. Mathews makes between anal and rectal diseases are simply due to the anatomical division which he makes, that these fistulas, for instance, are really described and are generally understood as results of little abscesses in the margin of the anus.

In regard to finding the internal opening before division of the fistula, I have an opinion different from those expressed tonight. It seems to me that if there are two or three openings—a condition that frequently exists—that the finding of one will not be sufficient to secure a perfect result from the operation. The teaching I got on the subject, however, was to push the probe as high up as possible and divide the fistula, whether I found the internal opening or not, and I think the best results are obtained by this method.

Dr. Cartledge: First I would say a word as regards the speaker's distinction of rectal and anal fissures. To a certain extent I

agree with the remarks of Dr. Roberts about the division of the rectum and anus. I think anatomically a good many gentlemen will differ on this distinction, and yet I see the point that Dr. Mathews wishes to present. It is one that will unquestionably result in good.

In reference to condylomata, I do not believe they are always the result of syphilis, but I do believe that the majority of them are syphilitic. At the same time I believe many of them are due to local causes. I have seen them in anal affections wherein no history of syphilis could be elicited, increased moisture seeming to be the cause. I believe that in many cases the condylomata might be specific and yet be cured without any internal medication.

As to the treatment of fistula by making an internal opening, I am rather surprised that there should be any doubt upon this subject. I thought it was a recognized fact that if you did not find the internal opening it was good surgery to push the probe through the gut and go on with the operation. I have certainly always done this.

Dr. Palmer: I have certainly seen condylomata that were non-specific effecting the verge of the anus. I believe that condylomata are not produced by any specific poison at all, that they are merely a coincidence in syphilis. Of course the sole treatment is to relieve the cause, which is the moisture. For this end I prefer calomel and salicylic acid to calomel and bismuth since the corrosive action of the acid hastens the cure. I see quite frequently ulcerations around the verge of the anus and yet never think of divulsion, but make applications of carbolic acid, and this after the use of a cold bath has in my hands invariably resulted in a cure. I do not believe that condylomata are necessarily the result of syphilis. As to marginal ulcerations they can be cured by frequent applications of carbolic acid.

Dr. Rodman: I would like to ask Dr. Mathews if Sir Benjamin Brodie, Gross, and others do not say that whenever a surgeon gets out of patience in searching for an in-

ternal opening, that he should stop and wait for another time to continue his search?

Dr. Mathews: Yes, that is the teaching of those gentlemen.

Dr. Grant: I am as familiar as Dr. Rodman with the teaching of Dr. Gross on this subject, and I am certain I have not only heard him say, but have seen him do just as I said, that is push the probe through the gut without taking especial time or pains to find the internal opening.

Dr. D. W. Yandell: In reference to fistula, I am naturally imbued with the teachings antedating Dr. Mathews. Brodie says if you do not find the internal opening to stop and wait. My own experience for many years has been the same as that of Brodie, which is, that you must find the internal opening. I have never failed to find the internal opening myself, not with one examination, or even two, but I have never made more than three without finding it. Sometimes I use catgut in searching for the opening, as it follows the track better than the probe. After making the second examination and failing to find the opening, I inject the fistula to determine whether it is open on that day. We all know that sometimes fistulas are open to-day and closed to-morrow. When I fail to get staining by the ink or substance used, then I wait sometimes two or three days, and I have never examined beyond the third day without finding the opening. I have made the internal opening by the probe on two occasions only, the gut being so thin that I inadvertently pushed it through. In these instances I had the satisfaction of finding that I had to do the operation over again. These two cases are the only ones in which I failed to effect a cure.

Dr. Mathews, closing the discussion, said: I think Dr. Roberts misunderstood me. I made this anatomical distinction between the rectum and anus for the purpose of illustrating what I was going to say, especially as to the treatment of anal fissure v. rectal fissure; that many times we do find an anal fissure that can be treated and cured by local applications, versus rectal fissures that

one can not reach to make local applications. Whether it is a correct anatomical distinction or not, I take the rectum proper to be from nine to ten inches long, beginning just above the sphincter muscle, and then I take it that the anus must begin there and come this way. Therefore I have been pleased to make the distinction between lesions outside the sphincter muscle and those inside. It may be that the former embrace some fibers of this muscle. But these can be seen and treated locally, while those that run up into the rectum can not be so seen and treated.

As to the cause of condylomata suggested by Dr. Palmer, I also quite agree that pathologically there can exist ulcerations very like these condylomata, and yet there is a distinctive appearance in syphilitic condylomata that is not present in benign ulcerations. Chancroidal ulcerations should of course be excluded.

In reference to the point made on fistulas, I expected that the Fellows would disagree with me, because the old masters have taught especially in reference to fistulas, that the internal opening must be searched for and found before division is made. Smith makes it, Gross makes it, Sir Benjamin Brodie makes it, and so it is no wonder that the general practitioner has the idea instilled into him that you must find the internal opening before operating.

Dr. Roberts very correctly says that it has long been taught, and we all recognize that "tags" around the anus should be cut off. This is my belief, and it is my teaching, but the peculiar character of the case I have cited is not a tag of skin. Taking one of the cases in point and looking at the anus, as far as the anus is concerned, and you will find no tag of skin, but a large, superfluous amount of skin. The only point I made was that all that superfluous skin should be removed.

I am not surprised that there are some differences of opinion in regard to these things, because they are matters of my own distinction, and not set down in the books.

E. R. PALMER, M. D.,

*Secretary*

## Reviews and Bibliography.

### The Relation of Alimentation and Disease.

By J. H. SALISBURY, A. M., M. D., LL. D., etc.  
332 pp. New York: J. D. Vail & Co. 1888.

When an author starts out by telling us that he was immediately and forcibly struck by the almost entire want of medical knowledge in regard to the true causes of disease, and that too at the very beginning of his practice, we can safely jump to the conclusion that if he lives out the ordinary allotment of years he will shed light on the dark places of medicine.

We first heard of Dr. Salisbury as the discoverer of the germ of malaria, and from time to time since then he has made discoveries so numerous and startling that they have obtunded attention.

The profession, with reference to his discoveries, has reached the state of men constantly exposed to the noise of the whirl of machinery, and who are startled only when the thing stops.

The doctor has made a multitude of experiments that would be of interest if the allowances for personal equation on account of bias did not remove them quite beyond the range of the most generous credulity.

The doctor is doubtless quite right in the conclusion that a large part of diseases is due to the food we swallow, but it may be doubted if any known form of diet can leave the system in a physical condition to be at all compared to the mental condition of one who swallows the contents of this book. It is to be hoped that if the author is to give us any more volumes, he will not hire his Boston-baked beans taken by proxy, but will, in his own person, give his readers the benefit of their good influence on the intellectual qualities.

D. T. S.

Disinfection and Disinfectants, Their Application and Use in the Prevention and Treatment of Disease, and in Public and Private Sanitation. By the Committee on Disinfectants, appointed by the American Public Health Association. Concord, N. Y.: Republican Press Association, 22 North Main Street. 1888.

**Rectal and Anal Surgery:** with a Description of the Secret Methods of the Itinerants. By EDMUND ANDREWS, A. M., M. D., and E. WYLLYS ANDREWS, A. M., M. D., of Chicago. 110 pp. Chicago: W. T. Keenes. 1888.

The Doctors Andrews, father and son, of Chicago, besides reaching honorable eminence in the department of rectal diseases, have also done much courageous and effective work in exposing itinerant charlatanism.

They can not be too much commended in their efforts, and it is only to be regretted that their example is not followed in a systematic and organized way by the profession in general.

When we consider that if the regulation of the country's coinage and currency were left entirely to the moral sense of the people, there could be no circulating coin or paper representative of wealth by reason of counterfeiting, that the safe possession of every species of property has to be secured by penal laws, it is more than astonishing that communities will overlook the motives of bad men and allow themselves to be plundered by dishonest pretenders in medicine, whether itinerant or not. It can only be accounted for on the supposition of ignorance on the part of the public, or the disposition to provide a border-land to which those who are hard to restrain in other walks can be driven. The public can reasonably calculate that it will be easier to prevent the currency from being counterfeited, and horses from being stolen, by allowing those who would otherwise engage in such callings, to rob with impunity the helpless sick in the garb of pretended physicians.

As a step in the right direction, we commend the work before us and the example of its authors.

D. T. S.

**Text-book of Medical Jurisprudence and Toxicology.** By John J. Reese, M. D., Professor of Medical Jurisprudence and Toxicology in the University of Pennsylvania; late President of the Medical Jurisprudence Society, Philadelphia, etc. Second edition, revised and enlarged. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street. 1889.

**Hand-book of the Diagnosis and Treatment of Skin Diseases.** By Arthur Van Harlingen, M. D., Professor of Diseases of the Skin in the Philadelphia Polyclinic and College for Graduates in Medicine; Clinical Lecturer on Dermatology in the Jefferson Medical College. Second edition, enlarged and revised. With eight full-page plates and other illustrations. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street. 1889.

**Pictorial History of Ancient Pharmacy,** with Sketches of Early Medical Practice. By Hermann Peters. Translated from the German and revised, with numerous additions by Dr. William Netter. Chicago: G. P. Engelhard & Co. 1889.

**Annual Report of the Supervising Surgeon-General of the Marine Hospital Service of the United States for the Fiscal Year 1888.** Washington: Government Printing Office. 1888.

**The Pathology and Treatment of Displacements of the Uterus.** By Dr. B. S. Schultze, Professor of Gynecology of the Lying-in Institution and of the Gynecological Clinic in Jena. Translated from the German by Jameson J. Macan, M. A., M. R. C. S., Eng., etc., and edited by Arthur V. Macan, M. B., M. Ch., etc., Master of the Rotunda Hospital, Dublin. With one hundred and twenty illustrations. New York: D. Appleton & Co. 1888.

**A Treatise on Headache and Neuralgia,** including Spinal Irritation, and a Disquisition on Normal and Morbid Sleep. By J. Leonard Corning, M. A., M. D., Consultant in Nervous Diseases to St. Francis Hospital; Fellow of the New York Academy of Medicine, etc.; Author of "A Treatise on Hysteria and Epilepsy," "Local Anesthesia," "Brain Exhaustion, with Some Preliminary Considerations on Cerebral Dynamics," etc. Illustrated. Price, \$2.75. New York: E. B. Treat, 771 Broadway. 1888.

**Favorite Prescriptions of Distinguished Practitioners,** with Notes on Treatment, compiled from the Published Writings or Unpublished Records of Drs. Fordyce Barker, Roberts Bartholow, Samuel D. Gross, Austin Flint, Alonzo Clark, Alfred L. Loomis, F. J. Bumstead, T. G. Thomas, H. C. Wood, Wm. Goodell, J. M. Fothergill, N. S. Davis, J. Marion Sims, Wm. H. Byford, E. G. Janeway, J. M. Da Costa, J. Solis Cohen, Meredith Clymer, J. Lewis Smith, W. H. Thomas, C. E. Brown-Sequard, M. A. Pallen, W. A. Hammond, etc. By B. W. Palmer, A. M., M. D. New York: E. B. Treat, 771 Broadway. 1888.

Report of the Surgeon-General of the Army to the Secretary of War for the Fiscal Year ending June 30, 1888. Washington: Record and Pension Division, Surgeon-General's Office. 1888.

The Modern Treatment of Diseases of the Kidney. By Professor Dujardin-Beaumetz, Member of the Academy of Medicine and of the Council of Hygiene and Salubrity of the Seine; Editor of the Bulletin General de Therapeutique, Paris, France. Translated from the fifth French edition by E. P. Hurd, M. D., Newburyport, Mass. Detroit, Mich: George S. Davis. 1888.

## Correspondence.

### PARIS LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Dr. Mauriac, a well-known syphilographer, has lately published a note on hereditary syphilis. The transmission of syphilis in a family may, he said, be effected in a direct or indirect manner; the author of this transmission is nearly always the husband. A husband, having had syphilis of which he is cured, may have connection with his wife without inconvenience; but if this woman in such conditions should become pregnant, and eighty-four days after conception certain accidents occur, syphilis will have been transmitted by generation to the mother. The embryo or germ has contracted syphilis which, by a "*choc en retour*," is propagated to the mother. The father may procreate syphilitic infants, but hereditary transmission is less frequent by the father than by the mother. The dangerous moment for the transmission of hereditary syphilis is that where the subject is under the influence of generalized roseola. The administration of mercury happily modifies this state in this virulent period and prevents the transmission by heredity, and it is always prudent to administer the mercury to attenuate the power of this transmission. The physician is often consulted as to whether a man once affected with syphilis can marry without any risk of infecting his wife. To this Dr. Mauriac replies, that according to circumstances he should wait a more or less long time, but as a general rule a syphilitic man is not condemned never to marry. Marriage should not be per-

mitted before the third year which follows the appearance of the primary chancre, and at least never before the completion of two years, and on the condition that the patient had followed a rational treatment. The interdiction should be absolute when the chancre has determined a phagedenic ulceration and accidents which have produced considerable damage to the organisms. In these conditions marriage should be postponed until cure or the disappearance of the accident. When the chancre is of a mild type, when there are only slight secondary lesions which yield rapidly to the influence of the treatment, as for instance roseola and mucous patches, the patient may without danger contract marriage eighteen months or two years after. In a word, the patient must in every case wait until the virulent syphilitic period be passed. If it is a married man who is affected with syphilis, the wife is inevitably condemned to be affected also. Sexual intercourse must be interdicted for at least one or two months; the infected husband should take every precaution to prevent contagion. The mercurial treatment should be energetically applied, the chancre should be well cauterized with the nitrate of silver, or even with the acid nitrate of mercury, to heal it up as soon as possible. When the chancre is cicatrized coitus may be permitted; but the husband must be given to understand that if his wife become pregnant the product of conception will necessarily be syphilitic. In continuation of this subject Dr. Mauriac remarked that syphilis is a frequent cause of abortion. One must wait twenty-five days or two months after birth to recognize syphilis in an infant which is suspected of being affected with the disease, as the the specific lesions never appear before this period. In the adult the evolution of syphilis is regular, the succession of the periods is marked, whereas in the infant there is a fatal irregularity and the accidents, which are numerous and terrible, condemn it to certain death. Another question frequently put is whether a mother who has given birth to a syphilitic infant may with impunity suckle it without contracting syphilis. Dr. Mauriac observes that the law of Coll, in England, even exacts that the mother alone should suckle her syphilitic in-

fant. At the end of two months the child may be made over to a nurse. Goat's milk may here with advantage be substituted for that of the mother. The treatment of syphilis in infants is an extremely delicate point, and requires great discrimination on the part of the physician as to the remedies to be employed, the basis of the treatment being mercury in its various forms as in the adult. The indication for the use of the iodide of potassium in infants rarely presents itself. Is it prudent to submit to mercurial treatment a woman during her pregnancy, the husband fearing to see the infant that is to be born affected with syphilis? This is useless, replies Dr. Mauriac, as the infection is eventual, and on the other hand the woman has conceived by the syphilitic father. The mother should be treated during her pregnancy only if she presents any syphilitic manifestations.

Dr. Ménierè, writing in the *Gazette de Gynécologie*, states that he finds solutions of acetic acid are as antiseptic as the solutions of carbolic acid. They are absolutely inoffensive, and never produce phenomena of intoxication; moreover they are powerful hemostatics. Acetic acid possesses, besides, the property of impregnating the tissues with much greater facility than the other antiseptic agents. It has a great advantage over corrosive sublimate, which, in presence of albumen, produces insoluble compounds. Acetic acid attacks instruments in a less degree than the corrosive sublimate. One might leave a pair of forceps for a quarter of an hour in a three-per-cent solution of acetic acid without producing the slightest injury to them. As soap does not dissolve in solutions of acetic acid, it would be necessary, after its employment, to wash the hands at least twice. Three-per-cent solutions are generally employed, but in cases of pre-existing septicemia five-per-cent solutions must be resorted to. These latter cause a slight sensation of burning in wounds. Dr. Ménierè concludes his note by recalling that the ancients employed vinegar scented with rose for the purposes of puerperal antiseptics.

Dr. Dulon associates quinine and antipyrine together to prevent the inconveniences arising from large doses of quinine. By mixing fifteen

centigrams of antipyrine with twenty-five centigrams of quinine he obtained an antipyretic effect equal to that which will be produced with seventy-five centigrams of quinine, without producing symptoms of quinism or stomachal intolerance.

At the Société des Sciences de Lyon, Dr. Icard related the following case: A lady, aged forty-four years, with rheumatic and syphilitic antecedents, but not having either sugar or albumen in her urine, was formerly affected with an ulcer of the stomach, which is now cured. She enjoyed good health, when she was seized, without appreciable cause, with a generalized pruritis which was most intolerable but without any eruption. In turns, arsenic, the bromide of potassium, atropine, sulphurous alkaline and emollient baths were employed, but without result. The author then had recourse to the salicylate of soda in doses of three grams per day. The pruritis, which lasted eight or nine months, disappeared the next day after the administration of the drug, and the cure was complete. Whether the cure was a simple coincidence or not he could not say, but he related the case, as others may be induced to try the remedy.

PARIS, January 11, 1889.

## Translations.

UNDER THE CHARGE OF I. N. BLOOM, A. B., M. D., DERMATOLOGIST TO LOUISVILLE CITY HOSPITAL, ETC.

TREATMENT OF BOILS IN THE EAR.—(Grosch, *Berlin Kl. Woch., Memorabilien*.) Furunculosis of the ear is an infectious disease occurring on one or more regions of the external ear passage. It is not a dangerous disease, but excessively painful, so that the patient is incapacitated for days or weeks from his daily occupation. Lately cocaine in five-per-cent to twenty-per-cent solutions has been recommended as an anesthetic, along with the former remedies, such as morphine, leeches, warm and cold cataplasms. Grosch has obtained but meager results from any one of these anesthetics—even cocaine.

Remembering the causal indication, he tried such disinfectants as carbolyzed gly-

erine, bichloride of mercury in alcohol and one-per-cent solution of sulphide of potash, with but little effect. He is opposed to incisions because he has noticed, as assistant in a large ear clinic, that in spite of cocaine they are excessively painful, that the exuding pus often gives rise to furuncles in other places, that when the furuncle is seated deeply the incisions can not be effectually made, and cause only useless, unnecessary pain.

Accident led him to discover a remedy which was of the greatest service in all such cases—the so-called liquor Burowi. This should be diluted with four times its bulk of water. Whether the furuncle fluctuates or not, the ear should be filled with the mixture every hour, and closed with absorbent cotton. In all cases, even in diffuse furunculosis of both ears, the result was highly satisfactory. In four hours at the most the pain was lessened so as to be bearable; in eight hours there was no pain. In from two to six days the patient was well. In no case did Grosch see new furuncles or granulations appear. Infiltrated, hard boils disappeared without suppurating; those cases which appeared before him with beginning suppuration healed by cessation and absorption.

The writer explains the effects of this remedy as follows: The fluid possesses the property of causing a swelling and sponginess of the tissues without solution of continuity. This flaccidity relieves pain by relieving the pressure on the nerve endings. The liquor penetrates sufficiently deep into the tissues to act as a strong disinfectant, and to kill the germs of the disease.

[Liquor Burowi is much esteemed on the Continent as a cold application in various inflammatory affections, such as acute eczema, when the skin will tolerate no kind of salve. It is made as follows:

Alumin. crud. .... 70 pts.;

Dissolve in aq. dest. .... 280 pts.;

Plumbi acet. crys. .... 28 pts.;

Dissolve in aq. dest. .... 280 pts.

Mix, filter, and dilute to 800 pts. Keep in tightly corked bottles. I. N. B.]

TREATMENT OF VAGINISMUS WITHOUT OPERATION.—(Lutand, *Journal de Médecine*, Nov., 1888.) Before advising a patient suffering from this disease to submit to the operation, which consists of stretching the vaginal sphincter under an anesthetic, Lutand counsels the following treatment: Introduce every day into the urethra a bougie composed of cocoa butter 10 grams, iodoform 1 gram, extract belladonna  $\frac{1}{16}$  gram. Inject three times daily a liter (about a quart) of very warm water, to which a teaspoonful of carbonate of soda has been added. Then paint the vulva and the vagina with a brush dipped in the following solution: Muriate of cocaine  $\frac{1}{20}$  gram, dest. water 2 grams. This treatment should be continued for a month. Intercourse should be attempted every two or three days, after having first lubricated the vulva and the penis with some substance like cold cream. Generally the vaginismus disappears after child-birth. Lutand advises a hypodermic injection of one sixth of a grain of muriate of morphine before intercourse. The sedative action of the morphine, especially on the genital system, makes coition endurable, and very often a single act produces pregnancy and a consequent cure of the vaginismus.

TREATMENT OF ANAL FISTULA WITHOUT OPERATION.—(Prof. Guyot, *ib.*) Fistulæ which do not cause pain should not be operated upon. The clothing should be soft and smooth, and extreme cleanliness should be observed, the general condition of the patient should be attended to, and of systemic remedies a mixture of the bromides and iron is especially valuable. The following is an excellent remedy: Bromide of potash, 10 grams; citrate of iron, ammoniated  $\frac{1}{2}$  gram; syrup of bitter orange peel, 100 grams. Tablespoonful should be taken morning and evening.

Topical appliances should be made after each stool. Here is a good formula for suppositories: Iodoform,  $\frac{1}{16}$  gram; extract of belladonna,  $\frac{1}{32}$  gram; cocoa butter, q. s. This should be applied after each defecation and on going to bed.

## Abstracts and Selections.

**APOSTOLI AND HIS WORK.**—It is fortunate that one creeps first, and walks later on. When I commenced my crusade many years ago on behalf of conservative gynecology I stood almost alone. When I argued that electricity, hygiene, and massage would do many things which the knife was called upon to do, I had not a sufficient array of facts to back my argument up, and I was somewhat mocked. But with the advance of years, as compensating perhaps for the aches and pains that fasten upon us, came riper experience, larger observation of fact, a study of the cases which other workers in a similar field had given to the public, until finally it culminated in a personal association with Dr. Apostoli, a personal investigation of his cases (reaching nearly 2,500), and a personal witnessing (for four hours at a time and three times a week) of the large number of cases that came to his clinic in the Rue du Jour. I was distressed to read the address of Dr. Bantock before the British Gynecological Society, because he vainly attempted to stay the onward march of scientific fact upon unscientific grounds. What Dr. Bantock has achieved no man may gainsay. He stands out eminent among abdominal surgeons. His results are beyond all praise. I have the most profound respect for him and his work. This he knows full well. It distressed me, I repeat, because to those who have neither the time nor the patience to read between the lines, or to weigh well the factors that go into the fashioning of a coherent argument, it might carry a certain prejudice against the most valuable agent in conservative surgery. What I have seen Apostoli do, Keith has done (a very Ajax among us in brains and work); Savage is doing; Engelmann has done; Martin, of Chicago has done; Sir Spencer Wells, whose name must carry reverence for the nobility of his deeds, has done himself, and seen done; W. W. Webb has seen in hundreds of cases here in Paris; and scores of observers, all the world over, are doing and repeating every week. The great, the salient objection raised by the obstructionists is that of its applicability to the treatment of uterine myoma. No honest man of ordinary intelligence who has made use of Apostoli's method, or who has seen it used, can possibly deny its absolute power to arrest the most dangerous symptom, hemorrhage; no honest man who will read

his numerous cases, some published and the others always to be seen at his clinic, in which this fact is on record, but must admit it. It is beyond all dispute that galvanism rightly applied will arrest hemorrhage from uterine myoma. In all of its clinical symptomatology is there a point of greater gravity? For what purpose does the surgeon perform the operation of Mr. Lawson Tait, of Birmingham (but the propriety of which operation I question seriously and with honest intent) to arrest hemorrhage? If galvanism could offer nothing more than the entire alleviation of the salient features in the symptomatology of uterine myoma without endangering in any degree whatever the woman's life, it should receive from us all possible honor. Why endanger a woman's life?—and history shows us that in the hands even of the most expert operator in the world women will die from opening the abdomen for any cause whatever. Is there a woman living who would run the risk of her life simply to be rid of a tumor which gave her no discomfort? But let us examine a step further. Galvanism will arrest the hemorrhage. Even Dr. Bantock must admit this, or confess that he has either not practiced it, or perhaps has had no time to read up the published observations of men of unimpeachable honesty. I assert that it will diminish the size of a myoma in certain cases without endangering life. I have seen it done, and have read of others doing it. There are cases reported in which septic peritonitis has resulted from galvano-puncture. My explanation is that the puncture was carried too deep, and was not done as Apostoli does it. I am also willing to admit, and I gladly admit it, that we are as yet only upon the threshold of our knowledge in this especial line, and that we need more cases and a much riper experience. I do not yet know that it will dissipate the tumor; I have not seen such an instance; but I believe the time to be in the near future when we shall be able to do even this. I only claim now that it will arrest hemorrhage, dissipate pain, improve nutrition, and diminish size without danger to life. Is there any thing known to our science which can offer so much? To arrest a uterine hemorrhage by Apostoli's method, it is *absolutely* necessary that the *entire membrane* inside the uterus should be *equally* and *uniformly* cauterized, and that a sufficient number of elements should be used. A current of from 100 to 300 milliamperes intensity can generally and usually be used with safety. I have seen

the latter employed many hundreds of times without any discomfort to the patient. It will, perhaps, be better to quote directly from Apostoli's writings:

"It is easy to make this accommodation in regard to the uterus. We wish to produce a vigorous cauterization without increasing the general interpolar intensity beyond the point easily supported: Lessen the intra-uterine electrode by a third, or fourth, or fifth of its original length, and forthwith the cauterization or topical action at the seat of contact will be thus made four or five times more powerful. I therefore lay it down as a rule in severe hemorrhagic cases, where it is expedient that a patient should bear a high dose of electricity without much suffering, that the intra-uterine electrode be reduced to a very trifling length; though, under such circumstances, it is essential that it be passed from one extremity of the cavity to the other, so that every part of the mucous surface is successively and completely cauterized. I began my operations in 1882 with a metallic sound, bare only at the extremity. In my first essays in cauterizing the mucous membrane of the uterus I had no other. Now I have improved the instrument, and my electrodes of carbon, though of different size, are all of the same length—two centimeters and a half. The metallic stem of this instrument is covered with caoutchouc, and on it at distances of two centimeters and a half, lengths which correspond with that of the carbon electrode, I have slight circular grooves marked. The electrodes are applied as follows: (1) After disinfection in some strong antiseptic solution, in order to secure full cauterization the instrument is driven as far as it will go, if possible to the end of the uterine cavity. (2) When the electrode is in this position, the highest bearable intensity of current is turned on, and we judge of the necessity of augmenting by the effect of previous operations. The intensity must be increased when the electrodes of larger volume, and consequently of more surface, are taken into use. (3) The first stage of cauterization being finished, the instrument is withdrawn just as much as the length of the carbon, and in that situation the second cauterization is effected the same as the first, and so on, changing the position of the carbon till all the interior of the uterus is cauterized section by section. To do this methodically, the index finger is passed into the vagina, and the pulp and nail pressed on to one of the circular grooves of the stem. While in shifting the seat of action the other

hand withdraws the sound, the index finger in the vagina remains immovable, and gives information as to the extent of change of position of the electrode by the touch of the following mark. (4) It is better, if possible, to cauterize the entire cavity at one sitting, letting each sectional cauterization last from three to five minutes, as the gravity of the case and the size of the cavity may show to be proper. (5) In continuing the treatment the duration and force of the current must be made to depend upon the effect produced by the cauterizations at previous sittings. (6) It is well to be aware that when the cauterization of the neck of the uterus is once made, the electrode, in passing through the internal orifice for further action, will occasion much more pain. I believe I was the first to mention the fact that the neck of the uterus, which is so little painfully affected by ordinary caustics, the hot iron or the knife, is, on the contrary, very sensitive, and much more so than the body, to the electrical current, either induced or continued. I think, in conclusion, I may say that it will henceforth be admitted we have in electricity a most powerful means of safely treating fibroid tumors, and that it will in future be felt as a duty by the surgeon to make use of it before adopting other measures. Carrying out my method as I have directed, I am convinced it will yield to others the same new and interesting results that it has been my good fortune to witness."

For the relief of pain, localized uterine pain due to interstitial compression, or extra-uterine pain (parametritis, perimetritis, etc.), we try, first, fixation (and Apostoli was certainly the first to point this out) with currents of high tension. In simple ovarian neuralgia it will always be valuable, but of no use in the suppurating form of peri-uterine inflammation. Here we use a galvano-chemical caustic or negative galvano-puncture. But I have seen cases of this kind get much better, and rapidly better, under the positive galvanic electrode within the uterus, and the negative attached to its bed of potter's clay resting upon the abdomen. During the spring of this year I saw Dr. Engelmann, of St. Louis, demonstrate Apostoli's method, in Martin's and in Olshausen's clinics in Berlin, in many of the commoner cases which apply for treatment, and which try the resources of the gynecologist to the utmost—*e. g.*, chronic cases of perimetritis with much posterior tenderness, ovarian pains, etc., and in almost every instance the patients experienced very great

relief. There will ever be cases which can only be permanently benefited by the aid of the surgeon; and since this is inevitable, I hold it to be the clear duty of every philanthropic person to relegate to the man who by experience and intelligence is properly equipped for such work, so that this craze of abdominal surgery which has taken possession of the profession at large may be checked. There will always be room for such men as Wells, Keith, Bantock, Savage, Thornton, Tait, Goodell, and others; but if every practitioner thinks himself sufficient for this the highest rôle of surgery, it will require more than the brilliancy of these brilliant men to counterbalance criminal records of unnecessary operations and bad results.—*Dr. H. R. Bigelow, London Lancet.*

**THE VALUE OF JABORANDI AND ITS ALKALOIDS IN THE TREATMENT OF BRIGHT'S DISEASE.**—The value of jaborandi and its derivatives in the treatment of the dropsy of Bright's disease can not be overestimated. By its use I have relieved in several cases some of the most distressing features of this complication, and prolonged or rendered less painful the termination of life in others; but in none has the drug been exhibited with such satisfactory results as in the following case:

S. D., aged nineteen, fisherman, came under my care in September, 1887. A dropsical swelling of the loose tissue in front of the neck, giving him the appearance of having a "dew-lap," was the first symptom that excited the attention of his friends. This had existed for two or three months before the patient came to me. He had no other feeling of discomfort; gave no history of chill, lumbar pain, or noticeable disturbance of urination. He found his breath a little short when pulling his oar—that was all, so he said. On being stripped, there was no edema of the legs or scrotum, and his mother, a very intelligent person, declared that his face or eyes had not been observed to be swollen at all. The urine was pale, sp. gr. 1012, and when treated with heat and nitric acid became almost like a blanc-mange, as nearly approaching the condition roughly described as "solid with albumen" as could be. How long this condition had persisted I could not say, but he was then following his usual calling as a boatman, often pulling a heavy punt about for an hour at a time; he was also carrying a number of buckets of water daily up a hill with a yoke and chains. I ordered him confinement to the house, and to be kept warm, giving him a dose thrice daily of steel, digitalis, and nitrous ether. Imme-

diately on treatment being commenced other symptoms manifested themselves, the legs, ankles, and face becoming swollen, the pulse weaker and more frequent, and he looked a "renal subject," which he did not before.

After a short time of treatment at home, during which matters mended not a bit, he was, by his friends' desire, transferred to Dover Hospital, where he remained for more than three months. While in the hospital different methods of treatment were employed, and at one time the patient seemed decidedly better, but he contracted a cold, and then became worse, and it seemed doubtful if he could live to return home. In the second week of February I was sent for by the patient's father, and found him exceedingly ill. He was propped up in bed, and dropsical from head to foot; his eyelids, which were distended with effusion, completely closed the eyes. His face was livid, and the swollen condition of the cellular tissue of the neck made it almost as broad as his shoulders. He coughed incessantly, there was copious intra-thoracic effusion, and the subcutaneous tissue all over the chest was "doughy" to the touch. His abdomen was as big as a barrel, and there was extensive edema of the genitals. His legs and thighs were enormously swollen, and water was exuding from them. He was passing a very small quantity of urine, which was of a dirty color, and loaded with albumen. As a last resource, but without expecting much from it, I determined to try the subcutaneous injection of hydrochlorate of pilocarpin, and the next day I gave two injections of a quarter of a grain each, one in the morning and the other late in the afternoon. After each dose I covered the patient thickly with blankets. The first effect was a flushing of the face, the saliva was secreted copiously, and within five minutes he broke out into a profuse perspiration. After the first injection he expressed himself as relieved, and he certainly coughed less. On my visiting him the next day, the lad's appearance was improved; he could see out of his eyes, he had passed a fair night, and the dyspnea was lessened. I continued two injections daily for three or four days, and after each administration he sweated most profusely. I found he became very faint soon after the injection, and to counteract this I gave him a good dose of gin and water before the next one, and repeated this each time afterward, when he never complained of faintness. Vomiting also occurred, once or twice severely, which induced me to lower the dose to one fifth of a grain, which I injected daily for nine or ten days. The improvement, which commenced early, was well maintained. At the end of a

week he could sit up in bed, the cough was much less, the thoracic effusion had completely subsided, and his arms and neck were becoming less edematous. The patient longed for my visits, and always expressed himself as feeling better after a "jolly good sweat." At the end of a fortnight his upper parts were free from effusion, but the abdomen was still much distended, and I hardly believed that we could get rid of an accumulation which at one time threatened to rupture the skin, and which it seemed that nothing but tapping could relieve. I then administered one fifth of a grain on alternate days, and kept this up for another fortnight. He was then passing his usual quantity of urine, the albumen much diminished in quantity; he sat up daily by the fire, and there remained but a little swelling of the abdomen and legs. I continued the injections till the remaining dropsy had subsided. The improvement was maintained, and, under a diet of plenty of milk and the administration of steel and convallaria majalis, he was able to go out of doors and enjoy life with comfort.

I can not say that the case is cured, as there is still about one twelfth of albumen present in the urine, and the legs occasionally "pit" slightly on pressure. But the lad looks extremely well, his appetite is good, he can walk up a stiff hill without losing breath, and can not believe that any thing is wrong with him. I think that the almost miraculous improvement which followed the use of the pilocarpin is worth recording, and (when one considers the usual helplessness of a condition such as I have described in a patient of this age and from such a cause) that jaborandi and its alkaloids must occupy the first place among known therapeutic agents in the treatment of cases of this kind. I have had good results from the use of an infusion made from the leaves of jaborandi, and drunk hot like ordinary tea; but the drawback appears to be the nausea so easily excited in these cases.—*Dr. J. G. Marshall, ibid.*

**ANEURISM OPENING INTO DESCENDING VENA CAVA; CAUSE OF SPEEDY DEATH IN HEART DISEASE.**—At a recent meeting of the London Clinical Society Dr. C. Arkle and Dr. Rose Bradford communicated a case of aortic aneurism rupturing into the descending vena cava. J. W., aged sixty-one, shoemaker, was admitted into University College Hospital, under Dr. Ringer, on October 20, 1887, complaining of pain in the chest and difficulty in breathing. He had had good health up to February, 1887, when he began to have attacks of pain in the right mammary region; this was also accompanied with dyspnea on

exertion. There was no history of syphilis or rheumatism. He had had winter cough for six years. State on admission: Great cyanosis of face. Collar of edema round neck, with great edema of right arm, and slightly of chest on right side. Abdomen and legs quite natural. Dilated veins at borders of sternum and lower margin of the thorax. Respiration 40, labored; pulse 106. Chest rigid and barrel-shaped. Visible pulsation in second and third right interspaces. Heart's apex beat in sixth space, just outside nipple line. A systolic thrill was felt over the area of visible pulsation, and on auscultation over the same area a loud murmur was heard. The murmur was harsh in character, occupied both systolic and diastolic periods, but had an exacerbation in its intensity during the systole. It never became inaudible, but existed during the whole of the cardiac cycle. The urine contained a trace of albumen. The day after admission the patient suddenly got out of bed, and on the nurse reaching him he was found to be moribund. *Post-mortem:* A large aneurism of the ascending and transverse portions of the arch of the aorta was found communicating with the vena cava superior about an inch and a half from its commencement by a small opening, evidently of some age. A second aneurism was found at the junction of the thoracic and abdominal aorta. The collateral venous circulation, arising from obstruction in the vena cava superior, was dissected out and described.

*Remarks.* (1) *The variety of the occurrence.* Seven cases are mentioned by Dr. Peacock in volume xix of the Pathological Society's Transactions. Dr. F. C. Turner reported a case occurring at the London Hospital in 1885; and in 1887 Dr. Gulliver showed a similar case at the Pathological Society. These two cases are to be found in vols. xxxvi and xxxviii of the Society's Transactions. (2) *The question as to when the rupture occurred.* This probably took place ten days before death, when the patient was seized with sudden pain in the neck, and rapidly became very cyanotic, with extreme edema of the neck and right arm. The characters of the opening with its rounded edges do not agree with the hypothesis that it occurred at the time of death, and would fit in much better with the view that it occurred some ten days previously. (3) *The significance of the murmur heard over the aneurism during life.* The murmur was continuous, but diminished in intensity during the last part of the diastolic period, and increased during the systole. It had a peculiarly harsh quality, resembling the bruits described in the case of arterio-venous aneurisms occurring elsewhere.—*Ibid.*

# The American Practitioner and News

"NEC TENUI PENNÂ."

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H. A. COTTELL, M. D., } - - - Editors.

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## TREATMENT OF PHTHISIS.

The Maryland Medical Journal, of January 19th, presents its readers with a practical paper on this subject by Dr. J. T. Smith, of Baltimore. The paper was read before the Baltimore Medical Society, from the Fellows of which it elicited a lively discussion. The essay opens with the appalling statement that during the past ten years 11,590 persons have fallen victims to phthisis in the city of Baltimore alone, making an average of 1,159 per year. The author takes a passing glance at the bacillus, and while admitting that its discovery is the greatest feat of modern medicine, owns that no scheme of treatment based upon its destruction within the body has been or is likely to be successful. But while, so far as therapeutic suggestions are concerned, the discovery of the bacillus throws no light into the darkness of this therapeutic morass, its hygienic possibilities are great and promise mitigation, if not control, of the disease among the coming generations.

He wisely counsels the thorough disinfection of the surroundings of the phthical patient and the destruction of the sputum. Wet sputum is harmless, but if the patient be allowed to spit where he pleases—on the

pavement or about the house—the sputum dries and the air becomes laden with bacilli, which, breathed by susceptible persons, find lodgment in the lungs and soon begin their work of destruction. Healthy air-passages effectually bar out the intruder, but a catarrhal condition invites their ingress and affords a ready nidus for their growth. It is true that there is nothing new in these statements, but it is equally true that the public is ignorant of this most potent factor in the transmission of the disease from person to person, and that the physician is by no means awake to its importance, and his clear duty in the hygienic management of his consumptive patients.

In discussing the principles that should guide us in the treatment of phthisis, the author takes for his text the following quotation from Flint: "I may claim in behalf of my clinical studies in relation to phthisis the establishment of the fact, that in a certain proportion of cases of this disease it is self-limited; in other words, it ends in recovery from an intrinsic tendency thereto. Of the forty four cases ending in recovery, in twenty-three there was no medicinal treatment to which an arrest of the disease could be attributed." "*Management and not treatment*," says Dr. Smith, "is the proper word to use; we have no specific, no combination or set of combinations of remedies which we can call curative. In fact, hardly any worse fate could befall a consumptive than the constant use of drugs."

Illustrative of his position, the author reports two cases, as follows:

"The first case is a young man in very moderate circumstances. When we first saw him he had been obliged to quit work, though he had still a fair measure of strength. He had been taking medicines, was confined to his room, and all had given him over to speedy death. We stopped all drugs, and urged his spending all time possible in the park near his house; not going there simply to walk about, but to sit there all he could. A marked improvement soon showed itself in his returning appetite and increased nutrition.

"The second case was a young lady, married, the mother of children, who had been sick less than a year. She was in comfortable circumstances and had a host of friends. We found her suffering from nausea, vomiting, and a most obstinate cough. Upon inquiry it was found that she was taking seven different kinds of medicine, and in addition, between meals, fed on jellies, beef tea, chicken soup, etc. The indications were obvious. The stoppage of all her medicines and her food restricted to three meals a day soon restored her stomach, and simply confining her to bed so markedly improved her cough that it required no attention; her stomach doing its duty and the cough no longer keeping her awake at night, her improvement was very marked in a couple of weeks."

Cases like these have doubtless been seen by every practitioner of experience; and this fact fully warrants the keeping of the reports of such before the eyes of the profession, since they so well illustrate the baleful effects of over-drugging and hygienic mismanagement, while the frequency of their occurrence shows that too many practitioners have but a muddy perception of principles involved in the management of the most common and fatal of all diseases. The author considers briefly the various crochets of the would-be therapeutic discoverers, such as Kremianski's attack in the front by inhalations of aniline, Burgeon's fire in rear with sulphureted hydrogen, the givers of germicides, by stomach and by inhalation, over-feeders, blood-drinkers, *et id omne genus*, and shows how they have succeeded only in doubling the burrow and "crawling out the hole they crawled in at."

His conclusion is the conclusion of the whole matter, and the practitioner who heeds it, while he will doubtless continue to write "phthisis" with provoking frequency upon death certificates, may solace himself with the thought that he has done all in the premises that rational medicine warrants, that he has forestalled infection in many quarters, saved the lives of some of the stricken, prolonged those of others, and mitigated the pangs of many hopeless sufferers.

He says: "Could we secure a thorough disinfection of all things used by our phthisical patients; could we persuade them to consult us more frequently, that we might control any departure from their healthy condition; could we induce them to live more in our parks and squares; and lastly, could we keep drugs and all forms of medication from them, except when under our direct supervision, we doubt not but that in the next fifty years a very marked decrease would be found in the reported deaths from consumption of the lungs."

### Notes and Queries.

DOCTORS DISAGREE.—The Cincinnati Lancet-Clinic of January 5th inst. contained a paper, read before the Cincinnati Academy of Medicine by Dr. E. S. McKee, of that city, in which he spoke of the new treatment of fibroid tumors of the uterus by means of electrolysis "as an efficient substitute for the knife." Dr. R. Stansbury Sutton, of Pittsburgh, has taken issue, and the last number of the Lancet-Clinic contains a challenge from Dr. Sutton, offering to furnish Dr. McKee with three women, each having a fibroid tumor, furnish all the required apparatus, and support him and the women in his private hospital in Alleghany, give him a year's time, and pay him \$1,000 in each case he succeeds. If he fails, Dr. McKee will be the loser. Dr. McKee accepts the challenge, provided the contest takes place in Cincinnati, not wishing to relinquish his practice for that time for the inducements offered.

IN THE TREATMENT OF TYPHOID FEVER Dr. William Carson, of the Cincinnati Hospital, gives muriatic acid ten drops, well diluted with water, every three hours, and three grains of quinine about every five hours, in cases which are moderate in degree. These cases are fed with milk every three hours, with the direction that it be swallowed slowly and in small quantities. He rarely experiences difficulty in

getting the patients to take milk during the whole course of the case. If there is repugnance to this food he supplants it by beef tea or concentrated-milk broth. He does not give much beef tea, or for a great length of time. The chicken broth he gives in large quantities and for some time if necessary. As the condition of the patient becomes more favorable, add a raw egg with whisky or wine, or a soft-boiled egg.

In severe cases the treatment is modified to suit the peculiarities of the case. High fever,  $103^{\circ}$  to  $104^{\circ}$ , is treated by cold sponging of the body surface not less than every three hours. If active delirium, with great wakefulness and twitching, is present, a warm bath is used for ten minutes, and repeated in three or four hours; if needed, antifebrine in ten-grain doses is occasionally used. This is not given continuously, but only to supplant the effect of the sponging.

The diarrhea he treats with turpentine, ten drops every three to five hours. This is especially demanded if the tongue is dry and the abdomen tympanitic. Hope's mixture is also used. The doctor does not interfere with the diarrhea if the stools are not oftener than three or four in twenty-four hours. Gallic acid is given for hemorrhage from the bowels. The dose is twenty or thirty grains every three hours, with occasionally some opium, one fourth grain every five hours. If perforation of the bowel occurs, large doses of opium are given, and as the peritoneum becomes more involved turpentine stupes are placed over the abdomen.

Severe headache and spinal pains are met with ten-grain doses of chloral, and sometimes a twenty-drop dose of bimeconate of morphia, which is repeated, if indications and effect require, every three hours. If vomiting is severe, give a half drop of creosote every three hours and suspend the other drugs. His cases are not treated with the belief that antipyretics have any important influence over the disease.

Dr. J. C. Mackenzie's routine treatment has been: Dilute muriatic acid, ten drops

after meals; Hope's mixture, half ounce every three hours when diarrhea was present in an excessive degree. Otherwise the treatment was mainly supportive and symptomatic. The supportive measures consisted of milk and beef tea, and as convalescence approached a diet of bread, rice, and soft boiled egg was cautiously added. The symptomatic treatment consisted in whisky and other stimulants, as indicated in a weak and frequent pulse, dicrotism, etc. Morphia is given in full doses in peritonitis, and morphia and lead acetate in intestinal hemorrhage.

Antifebrine he gave only when there was a continued high temperature of  $103^{\circ}$  to  $104^{\circ}$  or over, with only a slight remission. Wet-pack was given in only three cases, and with no satisfactory results. In some cases, after giving antifebrine, the pulse became better and stronger. The administration of antifebrine was always followed by profuse sweating and severe chill; the giving of an ounce of whisky prevented the chill. The effects of the antifebrine were noticeable within forty-five minutes after the administration, and lasted from four to eight hours. Atropia, in doses of one ninety-sixth to one sixtieth of a grain, failed to check perspiration in any marked degree.

THE AMERICAN ACADEMY OF MEDICINE.—In a recent number of the *Journal of the American Medical Association* there appeared a criticism of the Academy which demands some notice. The first requisite of a critic appears to be that he should be entirely free from such restrictions as might be imposed upon him by a more or less intimate acquaintance with his subject. In this respect the writer for our contemporary is evidently well qualified for critical work.

He finds fault with the Academy for not having exerted a telling influence in favor of improving the system of teaching in the medical schools. Had he taken the trouble to read the constitution of the Academy, he would have found its objects, as there stated, to be three:

1. To bring those who are alumni of classical, scientific, and medical schools into closer relations with each other.

2. To encourage young men to pursue regular courses of study in classical and scientific institutions before entering upon the study of medicine.

3. To extend the bounds of medical science; to elevate the profession; to relieve human suffering, and to prevent disease.

Nothing is said here about elevating the standard of medical colleges, which can only incidentally be brought in as a part of the duties imposed upon itself by the Academy. Its special and particular function is that of improving the preliminary education of the student. We know that this object has been persistently followed by members of the Academy with whom we are acquainted, and that they have used their influence to further the exaction of preliminary requirements by the colleges, and have sent would-be medical students back to preparatory schools when they have shown themselves deficient in that education which is fitting and needful. We do not wish to be understood as intimating that others have not done as much, or that the sole credit of agitating this much-needed reform is claimed by the Academy. But its members have done their full share.

In the same communication the writer says that the Academy wandered from its path by listening to papers on the "treatment of uterine affections by other than surgical means." As the writer could not possibly have heard or read the paper referred to (which was not read, and has not been as yet published), he could hardly form much of an opinion upon its opposition to the Academy. This paper called attention to the tendency of specialists to neglect all except their own favorite methods. Instances were given where laparotomists had recommended their own operation for cases in which the simpler and less dangerous methods which are at the command of every physician proved amply sufficient to effect a cure. How are we to combat this growing tendency? As the

specialism grows more strict, until men devote their lives to single operations, the necessity of a class of advisers who occupy a neutral but higher plane becomes evident. Tait believes in nothing but laparotomy; Apostoli practices only electrolysis. Who is to say then, in any given case, to which of these men the patient must apply? The question can not be left to either of them, because they are interested parties, and each knows only his own method. Obviously, the family physician is the only one who is competent to decide the matter. But is he competent? If not, he *must* become so. Otherwise the profession loses its cohesiveness, and its various members assume the relation of South-street merchants, each with goods to sell, and seeking by every means to attract customers to his shop.

To so elevate the standard of the family physician that he may intelligently decide whether to call the greatest of surgeons or the first electrician of the day to his assistance is the object before us, and the first step in pursuance of this object is that advocated by the Academy. Let the edifice of medical study be built on the broad and deep foundation of a thorough classical and scientific education.—*Phil. Med. Times*.

**MEDICAL VOLAPÜK.**—Dr. Nicolas, a gentleman with evidently a strong faith in his cause, advocates, in the *Journal de Medecine de Paris*, the adoption of the international language for medical purposes. His sketch of Volapük is flattering to that tongue. The article is abolished, and, better still, there are no genders. We agree with Dr. Nicolas that the presence of a declension is an obstacle to the diffusion of the language. As the cases are said to cover indefinite shades of expression, as in German, we doubt that such an arrangement would be tolerated outside of Germany, German Switzerland, German Austria, and the "Pennsylvania-Dutch"-speaking population of the United States. The lexicology of Volapük will be especially important to medical writers who believe in the establishment of that language. The cutting down of consonants and vowels would play havoc with roots of Græco-Latin

words, so abundant in medicine, and so generally understood as to answer most of the objects of a universal language. Terminal syllables modify the sense of roots. After the roots have been learned, however, the modifications must not only be learned, but understood. Thus "eye" is *log* in Volapük. *El* being a "professional termination," *logel* means "oculist." The adjectival termination *ik* makes *logik*, "from whence 'logamikel,' optician." Why "from whence?" How can *el* added to a simple root be universally understood to imply a professional man, and the same *el*, added to the adjectival modification of the root, be safely made to convey the idea of a tradesman? A Volapük paragraph on "Professional Etiquette," a fine familiar subject for the beginner, would be very interesting to study. Dr. Nicolas can not see his way to forming from *log* words to express "ophthalmia," "cataract," or "blepharitis." We can not help him. The building up of roots taking in tow a string of modifying terminals could alone settle the question on Volapük principles, and this arrangement would lead to endless confusion in medical literature. The literal translation of any word would be no guarantee of its true sense, just as *beispiel*, the German for "example," has been rendered "by-play" by ignorant yet too philological Britons. The use of prepositions, or of verbs which more or less obviate their use, would lead to inextricable confusion whenever a Frenchman attempted to explain a clinical history or pathological report to an Englishman or a German, for precision is absolutely imperative in such reports. To ask for a pint bottle of claret or the way to the post-office can often be done by means of nouns, infinitives, and pantomimic action. Volapük might prove of real use, under similar circumstances, in Russia, Portugal, or Hungary. But for medical literature and for learned society oratory the new language would be impracticable. The bulk of the profession in the British Empire and the States read few or no foreign works. On the other hand, there are plenty of doctors who make capital translations of French and German medical writings. Far easier and infinitely more profitable would it be for any medical man to learn the tongues of

Voltaire and Goethe than to attempt to get up an artificial dialect, devoid of precedents, prestige, or poetry, and to learn how to express "eye," "oculist," "visual," "ophthalmia," and "optician" by a root and terminals in such a manner that a foreign Volapük-scholar may by chance understand him.—*British Medical Journal*.

**ACTION OF DRUGS ON THE UTERUS.**—At the meeting of the Academy of Medicine in Ireland, Lombe Atthill (*Lancet*) discussed the asserted action of drugs on the utero-ovarian system. He was satisfied that no ordinary medicines produce any effect on menstruation when taken during the flow, excepting only the drastics. He doubts whether ergot, savin, quinine or strychnine have any appreciable action on the muscular fibers of the normal uterus. Astringents are useless in menorrhagia and metrorrhagia, including tannin, gallic acid, the mineral acids, etc., in this condemnation. Full doses of tincture of iron are sometimes useful, but only in anemic women; while he places reliance in ergot alone. In malignant disease he was not so sure that Chian turpentine checked the hemorrhages.—*Phil. Med. Times*.

**EFFECT OF PETROLEUM ON THE HUMAN BODY.**—Petroleum certainly has been used medicinally for a long time—long before the discovery of an oil well. In an issue of a stray medical journal, some twelve years ago, I read an article in which petroleum was highly recommended in spasmodic croup. In the neighborhood in which I practiced some ten years ago I found "kerosene" used frequently as a domestic remedy, with apparent success, in false croup. Within the last ten days I had an obstinate case of this kind. Along with remedies prescribed by me one night when bad, the child was given kerosene. He was better next morning, continued to convalesce, and is now well. What credit can be given to petroleum in this case is, of course, uncertain. During my college days, in Western Pennsylvania, I had a near relative who

was sorely afflicted with asthma. His remedy for the attack was a teaspoonful of kerosene taken early. A few years ago a lady of Baltimore told of a friend who had been very much emaciated, and supposed to be in the later stages of consumption, but who was then in robust health and quite fleshy, apparently restored by the use of crude petroleum. As a rubefacient it is in common use here by the laity, is very efficient, and produces very decided effects if confined. That it is not toxic in pretty fair doses is seen by the following: An elderly gentleman, going to take an evening dram at home in the dark, mistook his kerosene jug for the whisky jug, put it to his mouth, and swallowed a fair allowance before he discovered his mistake. He hurried to my office to know what to do. His face was somewhat flushed and the pulse full and frequent, mostly, I thought, from his alarm. I gave him nothing but assurance, and no ill effects followed.—*J. B. Amberson, M. D., ibid.*

**ACTION OF THE NERVES ON THE SALIVARY SECRETION.**—M. Gley, the physiologist attached to Professor Germain Sée's service, has seen that under certain circumstances the excitation of a central end of the sciatic nerve, in place of increasing the secretion of saliva, has decreased it; and following this up he noticed that when the gland was actively secreting, as, for instance, when the chorda tympani was irritated, then the excitation of the sciatic would stop the secretion. But the excitation of both must be done quickly, for if a little time is allowed to pass the sciatic will no longer respond. Besides this, if pilocarpine is used to provoke the secretion of saliva, the excitation of the chorda tympani will not increase the effect. M. Gley thinks that this effect is something similar to what M. Marey calls the phase of repose, as during systole the heart will no longer answer to irritation. M. Brown-Sequard also showed that when the iris was contracted new excitation would only bring about a relaxation. These facts seem to prove that, when

an organ is in full action, increased nerve action or excitation will only bring about the contrary effect. M. Brown-Sequard himself, in reply to the above, said that it was something like emotions which will stop the salivary secretion on certain occasions, and that a cause that determines an inhibitory phenomenon can, in other conditions, produce the inverse action.—*Ibid.*

**ABORTION IN CHICAGO.**—The Chicago Times has recently been investigating the subject of criminal abortion in Chicago by means of a decoy, who visited a large number of midwives and physicians, pretending she was pregnant, and asking them to help her out of her dilemma. The results of this investigation were published in December, and they show that a woman who is ready to undergo the risk of an abortion in Chicago need not search hard to find a medical man to share them with her for a consideration.

The issue of the paper for December 17th contains a list of midwives and physicians in Chicago who would bring on an abortion—one of the latter being the official surgeon of the Police Department, and a supplementary list of men who declined to commit this crime themselves, but recommended others who would do it.

The same issue contains a letter from Dr. Doering, President of the Chicago Medico-Legal Society, expressing approval of this investigation and promising the support of the Society to its work. This fact may be taken as an index of the attitude of every decent medical man in the United States, for there are no more uncompromising enemies of the crime of abortion for convenience than physicians; and the fact that some men or women, whom the lax laws of most of the States permit to practice medicine, are willing to use the knowledge they have in an infamous way simply illustrates the adage that black sheep are to be found in every flock.

We can not approve of the sensational way in which the Chicago Times has been exploiting its discoveries in regard to the crime of abortion in Chicago, and fear that it may do much harm by advertising the methods of

abortionists; but we trust that this serious disadvantage may be offset by the fact that it is also calling attention in a most striking way to the heinous character of this offense against public morals.—*Medical and Surgical Reporter*.

FORMULA FOR PRODUCING LOCAL ANESTHESIA.—Dr. J. M. Lewis, of Mexia, Texas, gives the following formula for injection before extracting teeth, in *Daniel's Texas Medical Journal*, October, 1888: .

Cocaini muriat ..... gr. viii;  
Chloralis hydrat..... gr. v;  
Acidi carbol..... gtt. iii;  
Aquæ destil..... f3 iii.

M. Sig: Inject two or three drops into the gum.

CASE OF PROBABLE POISONING WITH CREOLIN.—So much has been written lately in praise of creolin as a harmless antiseptic that the following case of probable poisoning with it, which occurred in the wards of Prof. Rosenbach, of Breslau, and is communicated to the *Therapeutische Monatshefte*, merits attention. In a primipara, twenty-seven years old, after evisceration of a dead fetus the uterus and vagina were washed out with a two-per cent creolin solution, in which procedure about one gallon of the solution was used. As the temperature rose on the next day to 102.4°, the uterus was again washed out with one quart of a one-per-cent creolin solution. On the following day the temperature was 100.5°, and for this reason, and because of a somewhat fetid discharge, the uterus was washed out with about one quart of a one-per-cent creolin solution, making the third washing out since the delivery of the woman, without any change in the good health of the patient occurring. In the evening about half-past six the uterus was washed out a fourth time. About nine o'clock the patient became suddenly pale and cold, and vomited violently. The temperature was 99°. The vomiting did not cease, sweating occurred, and at eleven o'clock the patient died in collapse and unconscious, after the temperature had fallen to 96.3°. The brownish-green vomitus smelt of creolin with extraordinary intensity. The distillate,

treated with bromine-water, gave a rich precipitate which had the characteristics of tri-brom-phenol. The urine also smelt strongly of creolin.

The result in this case can not be attributed to heart failure, because the patient was pretty well just before death; nor to puerperal sepsis, for the result of the autopsy is opposed to this. Poisoning with creolin is indicated by the similarity of the symptoms to those of carbolic-acid poisoning, by the unexpected death in collapse, the negative result of the autopsy, and by the character of the urine and vomitus.—*Wiener Med. Presse*.

A THREATENED REVOLT OF MEDICAL STUDENTS.—The trouble in the Medical Department of the University of the City of New York, December 29th, is not yet at an end. The students, it may be remembered, objected to the selection of a son of ex-President Woolsey, of Yale College, to be Professor of Anatomy, when they desired a favorite instructor, Dr. Weisse, to receive the appointment. In an address to the students, January 2d, Vice-Chancellor MacCracken said that Dr. Woolsey had been definitely decided upon as the new professor, and that Dr. Weisse's resignation had been accepted. Dr. Woolsey gave his first lecture January 3d, and the threatened revolt did not come off at that time. A few of the students left the room, but almost all remained, listened to their new lecturer with respect, and applauded him when his lecture was completed.

On January 14th, however, eighty-six dental students presented a paper to the Faculty, formally notifying them of their withdrawal from the University. This secession includes all of the dental students in attendance. It is also said that the withdrawal of A. J. Walsh has left the college without any one who knows the secret way of preserving bodies. The Faculty is therefore obliged to secure fresh bodies for dissection.—*Medical and Surgical Reporter*.

TRANSPLANTING A RABBIT'S CORNEA INTO THE HUMAN EYE.—Dr. Chisolm now writes: "The transplanting of a disk of rabbit's cornea for the purpose of rendering the central portion of an opaque human cornea useful is

in this case already so much of a success as to warrant its repetition on any suitable case which may present itself."

From the description which Dr. Chisolm gives of the condition of his patient at the time of the operation, I am inclined to think it was favorable. The cornea was extremely vascular, being covered with a fleshy layer of granulation tissue.

The transplanted button has been gradually clearing up, and at present the patient can "see persons ten feet off, but not to recognize them."

This operation is applicable to only a very limited class of cases. Dr. Chisolm said: "All cases of corneal blindness are not suitable cases for transplanting. Most of such diseased eyes are the sequel of perforating or sloughing ulcers of the cornea, with amalgamation of iris and cicatricial tissue, and with no aqueous chamber. The *sine qua non* of a proper case for operation is a perfect elastic membrane of Descemet and a normal anterior chamber filled with aqueous fluid. The lens and iris must also be intact, with a free pupil. For successful transplanting there must be a transparent membrane of Descemet as the foundation upon which to plant the graft."

The result in this one case establishes this operation as justifiable in a certain class in which all milder means have failed to restore any vision.—*Medical Record*.

ROYAL ACADEMY OF SCIENCES OF TURIN: THE BRESSA PRIZE.—The Royal Academy of Sciences of Turin, in accordance with the last will and testament of Dr. Cesare Alessandro Bressa, and in conformity with the programme published December 7, 1876, announces that the term for competition for scientific works and discoveries made in the four previous years, 1885-'88, to which only Italian authors and inventors were entitled, was closed on December 31, 1888.

The Academy now gives notice that from the 1st of January, 1887, the new term for competition for the seventh Bressa Prize has begun, to which, according to the testator's will, scientific men and inventors of all

nations will be admitted. A prize will therefore be given to the scientific author or inventor, whatever be his nationality, who, during the years 1887-'90, according to the judgment of the Royal Academy of Sciences of Turin, shall have made the most important and useful discovery, or published the most valuable work on physical and experimental science, natural history, mathematics, chemistry, physiology, and pathology, as well as geology, history, geography, and statistics."

The term will be closed at the end of December, 1890.

The value of the prize amounts to 12,000 Italian lire.

The prize will in no case be given to any of the national members of the Academy of Turin, resident or non-resident.

A. GENOCCHI,

*The President of the R. Academy.*

A. NACCARI,

*The Secretary of the Committee.*

TURIN, January, 1, 1889.

THE QUALITY OF ANESTHETICS IN NEW YORK.—The chemist of the New York State Board of Health reports that in 1887 there were 326 samples of official drugs examined and tested as to purity. The results are not very striking, except as regards chloroform and ether. It was found that safflower is very often substituted for saffron, and that washed sulphur is often impure. Of 53 samples of chloroform, 39 were of good quality, 10 fair, 4 inferior. Of 53 samples of stronger ether, there were 20 of good quality, 5 fair, 26 inferior. Over half of the ether dispensed was of bad quality.—*Medical Record*.

ASPHYXIATION BY ILLUMINATING GAS.—At a recent meeting of the American Gas Light Association, of Toronto, the following rules were given, to be followed when men are overcome by gas:

1. Take the man at once into fresh air. Don't crowd around him.
2. Keep him on his back. Don't raise his head, nor turn him on his side.
3. Loosen his clothing at his neck and waist.

4. Give a little brandy and water—not more than four tablespoonfuls of brandy in all. Give the ammonia mixture (one part aromatic ammonia to sixteen parts water) in small quantities, at short intervals—a teaspoonful every two or three minutes.

5. Slap the face and chest with the wet end of a towel.

6. Apply warmth and friction if the body and limbs are cold.

7. If the breathing is feeble or irregular, artificial respiration should be used and kept up until there is no doubt that it can no longer be of use.

8. Administer oxygen.—*Maryland Medical Journal*.

**DANGERS OF PRESCRIBING FOR THE UNSEEN.**—The following story, translated from an old French manuscript of the thirteenth century, is applicable to the present day. The credulity of many persons, even those of some intelligence, still leads them to apply to quackery either in the form of sending handwriting, photographs, locks of hair, or something to a distance for their fortunes, traits of character or health.

There was, once upon a time, a country curate who was continually pitching into his parishioners because they consulted an old witch, who treated them after only seeing the clothes or belt of the ill one.

In spite of his exhortations he could not make them renounce this deplorable custom. What was he to do, how to manage it?

He pretended he was ill, and told them to carry his belt to the old sorceress and to ask her what the one to whom it belonged was suffering from. He told them, above all things, not to reveal either his name or position.

The good woman took the belt, examined with attention its length, its breadth, the holes by which the clothes were attached to it, and then put herself to reflection.

It may be well to remark that the curate was large and fat.

At the end of an instant the wizard pronounced her judgment with a profound air:

"This belt," said she, "is that of a preg-

nant woman, and her disease is nothing else than that of child-carrying!"

The messenger of the curate returned abashed, and he had no more trouble in demonstrating the absurdity of their superstition.—*Ibid*.

**DANGER FROM POPULAR PRESCRIBING.**—The self-prescriber has already heard of sulfonal, and is taking it in the maximum dose in order to produce sleep. He is also recommending it to his friends who can not sleep, in doses which are not free from danger. The popular use of antipyrin, which has been going on for over a year, has done no little injury; we have known thirty grains to be advised by one layman to another as an initial dose. We predict that the time must come, through the multiplication of these potent neurotic medicines, when physicians will insist upon the non-renewal of these potent pre-criptions by pharmacists without a written order. It seems to us quite probable that we have simply arrived at the threshold of this department of chemical work, and that the profession will be compelled to throw additional safeguards around the unauthorized use of these powerful agents.—*Medical News*.

[For this state of affairs the profession and it alone is to blame. All new powerful drugs should be dispensed by the physician himself, the effects carefully watched, and no hint given the patient of their names or nature.—*Eds. A. P. & N.*]

**FAITH CURE.**—There are dangers incident to attending faith-cure meetings, even as a spectator. According to a newspaper report, Robert Watts, a young farmer, went to Springfield, Ill., the other day to attend a faith-cure meeting. Among the recent converts is Anna Delany, about twenty years old. Since her conversion she has become a regular attendant at the meetings, going into trances upon the slightest provocation. While in a trance she sometimes walks about the hall. At a meeting last week the girl was in a trance as usual, and in walking up and down the aisle passed Watts, who was standing in the rear

of the hall. As she did so she caught hold of his hand with a grip so firm that, although he struggled to get loose, he was unable to do so. Several men tried to stop the girl, but she continued walking, and Watts was compelled to follow her. It was four o'clock in the afternoon when Anna took him by the hand, and it was seven and a half hours before he regained his freedom. When she walked, Watts had to walk, and when she stood, he had to stand. Shortly before midnight Miss Delany fell to the floor. She was placed on a stretcher, and in about five minutes let go her hold of Watts, greatly to that individual's relief. The young farmer lost no time in getting out of the hall. His hand was swollen so that he was hardly able to use it. Miss Delany came out of the trance later, but had no recollection of what occurred."—*Boston Medical and Surgical Journal*.

**POISONING BY ANTIFEBRINE.**—A book-binder, aged thirty eight years, obtained thirty grains of antifebrine from a druggist in Berlin for a headache, and, after twenty-four hours, thirty grains more, each quantity to be taken at one dose. A quarter of an hour after taking the second dose the patient experienced great depression, with cold sweats, vertigo, anxiety, and heavy palpitation of the heart, with small and frequent pulse. The face and hands soon became dark and bluish. After the administration of some black coffee and castor oil, and the application of a mustard plaster to the abdomen, the blue color disappeared; by degrees the other symptoms followed, except the faintness, which lasted several days.—*Apoth. Zeitung*.

**EXTERNAL APPLICATION OF CHLORAL HYDRATE IN NIGHT SWEATS.**—Dr. Nicolai (*Gazette Médicale*) has obtained very favorable results from the use of chloral hydrate in the night sweats of phthisis. Every night before retiring the entire body of the patient was sponged with the following:

Chloral hydrate.....	5ij	:
Alcohol.....	} aa 5ij. M.	
Water.....		

Should this not suffice, the patient's night-dress is saturated with this solution, then allowed to dry, and worn.

This mode of treatment also gave excellent results in the night-sweats of children, the result of phthisis. Two or three of these spongings will generally suffice to check a sweating which has persisted for two or three weeks.—*Medical News*.

**SURGERY RUN WILD.**—Prof. Von Nussbaum has been instructing and perhaps regaling the young generation of German surgeons by a brave pamphlet on "Surgical Mishaps." Among the instances is the following case of a peasant who many years ago was taken to the clinics of a great medical center in order to be treated for multiple ulcers of both legs. On being examined on the operating-table the right leg was pronounced to be curable, while the left was declared to be incurable and to require amputation. The amputation had scarcely been performed when the surgeons found, to their great horror, that they had amputated the wrong leg! Their chagrin was still increased when the right leg, which by accident had been saved, healed in a short time spontaneously.—*Boston Medical and Surgical Journal*.

**STROPHANTHUS IN GOITRE.**—The use of strophanthus tincture is recommended for the relief and cure of exophthalmic goitre, and it has been suggested that it may be reinforced by ergot with advantage; the former may be given in doses of from two to five minims three times daily, and the latter a dram or half that quantity at bed hour. It is believed that the strophanthus will lessen the rapidity of the heart's action, and that the ergot will have its characteristic action upon the arterioles supplying the thyroid body.—*Medical Bulletin*.

**FIRST DOCTOR:** "Got back already from Arizona?" **Second Doctor:** "Yes; I don't like it out there." "What's the matter?" "If you have a case of smallpox and can't report it to the Board of Health, you are fined and imprisoned. If you do, the relatives fill you full of buck shot. It ain't a healthy country for a young doctor."—*Medical Standard*.

THE water-supply of cities and towns is a matter of no small importance, as it may be put to such uses as will endanger the lives of the community. A case of this nature recently came under the observation of the health officer of Calcutta, where an outbreak of cholera followed upon the adulteration of the milk-supply from an impure source.—*Medical Bulletin*.

“THERE are just sixty women who have taken medical diplomas entitling them to enter their names on the British register of duly qualified medical practitioners,” writes a correspondent to the San Francisco Call. “Of these, two are dead, and seventeen have gone to India, leaving only forty-one in Great Britain. Of the forty-one, twenty-one are engaged as lecturers or instructors in the London and Edinburgh medical colleges for women, or as medical officers to hospitals, dispensaries, or other institutions, leaving only twenty who depend solely on private practice.”

SMALL PRACTICE.—Young Doctor: “Yes, I expect that it will go pretty slow when I first open an office until I get started a little.” Old Doctor: “Well, you bet it will. Why, when I first hung out my shingle I sat in my office for three months and only had one case.” “Whew! That was pretty tough, was n’t it? Only one case! and what was that a case of?” “A case of instruments.”—*Puck*.

LEPROSY INOCULATED IN A CRIMINAL.—Some time ago, in commenting upon the bacteriological work of Dr. Arning, we stated that he had tested the question of the inoculability of leprosy practically upon a convict at Kearn. The operation was done in November, 1885. It is now stated that the man is suffering from tubercular leprosy.—*Medical Record*.

ACONITIA IN MIGRAINE.—Dr. Taylor, in the Peoria Medical Monthly, relates a case where a young lady took  $\frac{3}{200}$  grain of aconitia at one dose. Marked symptoms of aconite poisoning supervened, which passed off in a few days. The migraine was relieved, and had not returned after the lapse of over a year.

SMALLPOX SPREADING.—Press dispatches indicate that smallpox exists in widely separated portions of this country. It is reported to be spreading in Albany, N. Y., and the inmates of the Auburn State Prison are to be vaccinated. It is also increasing in New Washington, O., to such an extent that business has been interfered with and trains are not allowed to stop. A few cases are reported from Newport, Ky. Italy is said to be the ground of a great epidemic of smallpox.

THE most heavily endowed educational institutions in the United States are: Girard College, \$10,000,000; Columbia, \$5,000,000; Johns Hopkins, \$4,000,000; Princeton, \$3,500,000; and Harvard, \$3,000,000.

A WOMAN in Edinburgh, Scotland, is reported pregnant at the age of sixty-two, it being her twenty-third time. She was also pregnant at the ages of forty-seven, forty-nine, fifty-one, fifty-three, fifty-six and sixty.

DR. THEOPHILUS PARVIN has been elected President of the Obstetrical Society of Philadelphia.

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### SPECIAL NOTICES.

Messrs. ELI LILLY & COMPANY, of Indianapolis, have issued a work entitled Hand-book of Pharmacy and Therapeutics. The aim, as stated in the introduction, is to furnish the busy practitioner a reliable means of ready reference, at once concise, systematic, and authoritative, to which he may refer with confidence in cases of doubt. Younger members of the profession and medical students will find this work full of suggestions. It will be sent free to any physician, druggist, or medical student by addressing Eli Lilly & Co., Indianapolis, Ind., mentioning this journal.

IRREGULAR MENSTRUATION.—T. J. R. Clarkson, L.R.C.P., L.R.C.S., Pateley Bridge, Leeds, England, says: My experience with Aletris Cordial is limited to one case. The patient, a young lady of twenty-one years of age, had never in her life been regular, the flow being very scanty. One dose brought on the discharge, which was more profuse than any she had experienced. She has been regular since. Of course it is difficult to believe that one dose could bring about this result, but nevertheless the fact remains that she has been regular since taking it, a thing she never was in her life before. I shall be glad to write you after a more extended trial.

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNĀ."

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*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.*

## Original Articles.

### MANAGEMENT OF THE SECUNDINES IN ABORTION.\*

BY JOHN G. CECIL, B. S., M. D.

*Assistant to the Chair of Obstetrics and Gynecology, University of Louisville, Gynecologist to Louisville City Hospital, etc.*

Goodell in apt phrase likens full term labor to the dropping of ripened fruit, and miscarriage to the plucking of unripened fruit. The first is a physiological process, the second is pathological. The management of the secundines in the one naturally differs much from that in the other. The management of the secundines in miscarriage is perhaps more unsettled at present than it was formerly. And this is by reason of the ardent advocacy by the later generation of obstetricians of what is termed *the immediate removal of the secundines*; and, moreover, what might not improperly be termed "meddlesome midwifery," at least in many instances, judging from the reports of cases found in current literature on the subject. With singular unanimity—a fact worthy of remark—the text-books advocate the expectant plan, or modification of it, while nearly all the recent contributions to periodical literature favor the immediate removal. Only one authority, according to Charpentier, in France, and that Guéniot, favors active interference; in Germany three or four, including Veit and Fehling; in England seven, among whom are Tyler Smith, Leishman, and Simpson; in America only Mundé ("many others," added by the editor). As in

other instances, so in this, the conservative position is safer and more acceptable to the majority of practitioners. Careful consideration of the facts and circumstances attending each case is more conducive to its intelligent management than the fatuous following of any inflexible rule applying to all cases.

Up to the end of the second month there is usually little trouble to be apprehended, especially in cases not brought on by instrumental or criminal means. The ovum, with its membranes, if left undisturbed to the course of nature, frequently are cast off together, making the abortion complete. Some authorities are of the opinion that, when miscarriage occurs during the second month and earlier, the expelled ovum is always entire with membranes intact, and when the membranes are ruptured it is evidence of criminal abortion. Bearing in mind the period during which the after-birth is developed, it is amazing to see records of cases, in the leading journals, of abortions occurring at two months, the placenta reported as being retained, necessitating, in the mind of the anxious attendant, the use of the curette for its removal.

In the third, fourth, and fifth months the connection between the membranes and placenta with the uterus is much more intimate, and a natural consequence is that miscarriage during these months is a much more serious affair. Because of this close adherence the termination of miscarriage at this age ought to be retarded, thus giving time for complete separation and consequent removal *en masse* of fetus and its secundines.

Miscarriage occurring later than the fifth month partakes more of the character of labor at full term, and should be treated according to the principles applying to such labor. The tampon, a valuable adjunct before delivery

\*Read before the Louisville Medical Society, November, 1888.

of the fetus at this period, is not admissible afterward for fear of concealed hemorrhage to a dangerous extent. To come now directly to the point at issue, namely, how should we deal with the secundines when they are retained: There can be no question but that their early removal is desirable in all cases; and all authorities agree that, when feasible, it should be done; but the feasibility is the point about which there is so much variance of opinion. The advice of the later generation of obstetricians above mentioned, when the membranes and placenta are imprisoned, is to dilate the cervical canal and deliver at all hazards, the supreme object being to deliver, and to deliver at once. This procedure, of course, necessitates the forcible dilatation of the cervix by the finger, tents, or metal dilators, and the use of the curette or placental forceps. Now there are many cases in which the probability of danger resulting from the use of the above means is greater than delay accompanied by proper treatment, even for several days. Furthermore, many of the cases cited to sustain the superiority of the practice of immediate removal of the secundines prove with equal weight the harmlessness of their retention for days and even weeks.

It is not claimed in this paper that there are not dangers likely to result from retained secundines, but the assertion is made that the dangers are not so grave as to impel the attendant to tear away from the uterine wall a placenta closely adherent, when the chances are that judicious delay would see the separation and expulsion without the risks incurred by the use of forcible means. The dangers are, recurrent hemorrhages to a serious extent and decomposition with absorption of septic matter. Hemorrhage should cause less apprehension than the onset of septicemia. In ergot and the properly applied tampon we have remedies that give perfect control of this danger. This leaves only septicemia to be prevented. This is the great danger and the one that naturally causes most apprehension. A question that may properly be sprung here, is the woman delivered with clean hands and with no unnecessary interference in any more danger of septic troubles arising from the re-

tention of the secundines than the one whose cervical canal has been rapidly and forcibly dilated and the closely adherent placenta scraped or torn away? It is hard to believe she is. If tampons are employed in connection with the expectant plan of treatment, they should be used under the strictest antiseptic precaution, implying in this statement a thorough vaginal douching before its introduction and before each subsequent reapplication. If septicemia for any reason is especially apprehended, the tampon should be renewed at short intervals, say every six or eight hours.

Upon the appearance of a fetid discharge the vaginal douche is called for; failing to destroy the fetor with this, the injection should be carried into the uterine cavity, and, to be effective, should be used at least every eight hours. When decomposition of the placenta or membranes has once set in the os internum will as a rule be found patulous, allowing the finger to pass into the uterine cavity. In case the retained portions are undecomposed, the cervix is usually found closed, and will not allow the passage of the finger without previous dilatation. As long as decomposing secundines are retained in the cavity of the uterus there is imminent danger of septic poisoning, and the sooner the cavity is cleansed the better. Every case of fetid discharge and odor is not of necessity going to be followed by septicemia, but it is a danger signal we do well to heed. Under such circumstances forcible dilatation, if required, must be resorted to, and the foul mass delivered with the finger if possible; with the dull curette in event of of failure with the finger. This should be followed by an antiseptic douche and the introduction of a pencil of iodoform to be left in the uterine cavity.

If antiseptic obstetrics has taught any thing, it is that a very small proportion of cases of septic infection are autogenetic. The natural deduction, therefore, is that miscarriages that are allowed to proceed according to nature's methods are less likely to be followed by this infection, or to demand active interference on the part of the attendant in the event of retention of the secundines. It follows thus that in such cases the expectant plan may be

followed with more confidence than in cases that have required aid in the delivery of the fetus, or that have been produced by criminal use of instruments. There is of course a limit as to length of time the secundines should be allowed to remain, notwithstanding there be only slight hemorrhage and no evidence of decomposition. Such a limit is difficult or impossible to fix, each is a law unto itself. Indefinite retention of the after-birth would inevitably result in a congested and hyperplastic condition of the womb, with all the attendant train of symptoms. As long as the womb is not empty there is danger, and after a delay of reasonable length, which will be determined by the condition and circumstances of each case, prompt and radical measures should be instituted.

The finger is a good dilator, and it is the best and safest curette. If, by reason of the very high position of the uterus, the finger is not able to reach the fundus, then the dull wire curette is admissible.

LOUISVILLE.

## CLINICAL COMMUNICATIONS.

BY S. G. DABNEY, M. D.

*Professor of Physiology and Lecturer on Diseases of Eye, Ear and Throat in Hospital College of Medicine, Vestal Surgeon to Eye and Ear Department of the Louisville City Hospital, Louisville, Kentucky.*

**I. ACUTE GLAUCOMA INDUCED BY THE INSTILLATION OF ATROPIA IN A MAN TWENTY-TWO YEARS OLD, WHOSE MOTHER HAD ALSO HAD GLAUCOMA.**—On December 28th Mr. B. consulted me in regard to his right eye. The patient is twenty-two years old, and a book-keeper by profession. He had been under my care in the preceding August for a mucopurulent conjunctivitis in the same eye, which had been relieved by the ordinary remedies, with the addition of a solution of atropia used to paralyze the accommodation, as the patient felt it necessary to continue his work with the unaffected eye. At the time of his visit in December there was nothing to be seen beyond the usual symptoms of a rather acute mucopurulent ophthalmia, and the same line of treatment which had proved successful in his former attack was again instituted, except that two drops of a four grains to the ounce solu-

tion of sulphate of atropia were instilled, whereas the strength of the solution used before was only two grains to the ounce. I should state here that the four-grain solution is very frequently applied, and is certainly not too strong unless there is some contra-indication to the use of a mydriatic. Some twelve hours after Mr. B.'s visit I was summoned to see him at his home, as he was suffering intense pain in the eye. When I arrived he told me that the pain had begun shortly after his call at my office in the morning, and toward night had become much worse; he had just suffered a paroxysm of intense agony which was now subsiding. On examination I found marked pericorneal injection, the whole ball, indeed, being very red, the cornea cloudy, the anterior chamber rather shallow, the eye sensitive to pressure, and its tension above the normal, the pupil widely dilated, as was to be expected, from the action of the belladonna. The patient could count fingers at a distance of ten feet. The diagnosis was acute glaucoma caused by the instillation of atropia. Although eserine is indicated in such a condition, it seemed permissible, in view of the fact that the pain was now subsiding, and that I had the opportunity to keep the patient under close observation, to abstain from any local treatment. Antipyrine, in dose of ten grains, was directed, and two doses gave such relief as to allow a sound and refreshing sleep. Next morning the eye was in all respects better; there had been no return of the violent pain; the pupil was less dilated and was distinctly oval in shape, the long diameter of the oval being transverse. The improvement was continuous, and in about ten days vision became normal, and the eye was well except for a slight remaining conjunctivitis. An interesting fact in connection with this report is that the mother of the patient was operated on for glaucoma some years ago. She was under the care of Dr. William Cheatham, of this city, to whom I am indebted for this information completing the history of my case.

**II. MORNING SICKNESS CAUSED BY ELONGATED UVULA.**—Says Sajous, *Diseases of the Nose and Throat*, page 296: "Nausea is a frequent symptom [of elongated uvula], most marked on rising, the upright position causing the uvula to rest against the base of the tongue."

The following case is of interest because of the intensity of this symptom, and because the other usual consequences of elongated uvula were absent: Miss I., age eighteen, placed herself under my care in November last for nasal catarrh. In relating the history of her case, she mentioned that for months she had been troubled with nausea on first rising in the morning. She did not suffer from accumulations of mucopurulent matter in the naso-pharynx, and consequently had none of the "hawking" which is a common cause of nausea in such conditions. She had little appetite for breakfast, and if she ate any was likely to vomit it up. The nausea disappeared by nine or ten o'clock in the morning. Various medicines had been used, but no relief obtained. She had no cough, no tickling in the throat, and no sense of irritation there. There was some thickening of the lining membrane of the nose, enlargement of the tonsil of Luschka and elongation of the uvula. The redundant portion of uvula was clipped off two months ago, and she has been entirely free from nausea since.

The nasal catarrh has been treated with the ordinary remedies, and the thickening at the roof of the mouth removed with Cohen's post-nasal cutting forceps; but the sick-stomach was promptly and permanently cured by the uvulotomy before the other features of her disease had been materially changed.

III. LARGE SYPHILITIC GUMMA IN THE NOSTRIL.—Mr. B. was referred to me by Dr. A. M. Cartledge on the 10th of last November. He gave this history: was twenty-eight years old, married, and the father of several healthy children; he denied having had syphilis. Four or five weeks previous to his visit to me he noticed an obstruction in his right nostril; this had rapidly increased, until respiration through that side was prevented; there was sharp pain in the nose and over the whole of that side of the head. On examination I found a growth over the lower left turbinated bone, occluding that nostril and pressing against the septum. The growth was hard and sensitive to pressure; the surface toward the septum was ulcerated; the corresponding ala of the nose bulged outward. The lymphatic glands at the angle of the lower jaw and in the neck of the same side

were enlarged, but no involvement was to be detected elsewhere. From the rapid growth, sharp pain, and implication of the neighboring glands, a malignant tumor seemed probable, all the more so, as the patient denied any taint of syphilis. Notwithstanding this, however, I prescribed fifteen grains of iodide of potassium three times a day, and soon increased the dose to thirty grains. No symptoms of iodism were produced, and the growth very rapidly disappeared; it seemed almost to melt away, thus establishing its syphilitic nature. The man afterward confessed that he had had a sore on his penis ten years before, and had taken some medicine which a doctor prescribed for him, but gave no further history of constitutional syphilis.

IV. CONCUSSION OF THE LABYRINTH FROM THE FIRING OF A CANNON.—On September 17, 1888, Mr. C. called at my office to have an examination of his ears made. He gave this history: He was seventy one years old and in excellent general health, exceptionally vigorous for his time of life. Up to the 17th of the preceding July he had possessed perfect hearing, and had never been troubled by noises in the ears; on the date mentioned, while at a summer resort in Wisconsin, a cannon was fired very near him, and he observed that "quick as a flash" his hearing was impaired and a singing like that of a tea-kettle began in each ear; both deafness and tinnitus still continued unchanged; he heard much worse in even a slight noise, and his own voice had a peculiar muffled sound to him. On further examination I found the hearing power for the voice not much diminished, while my watch, which should be heard at forty inches, was not audible even when pressed against either ear; the external meatus and drum membrane of each side were normal, and inflation with the Politzer bag, though clearly felt, had no influence on the deafness or tinnitus; the nasal passages and pharynx were clear and healthy; the tuning fork C<sup>2</sup> was heard much more distinctly through the air than through the bone; it was scarcely perceptible when pressed on the mastoid process, while it could still be heard for many seconds when held in the air by the ear. The diagnosis was concussion of the labyrinth,

and was based on the following grounds: (1) Aerial conduction much better than bone conduction; (2) hearing very much worse in a noise; (3) conversation heard relatively much better than the watch; (4) the history of the case as related by the patient.

No treatment was advised, for after consultation with the family physician, Dr. Hollo-way, of Louisville, no general measures seemed to be indicated, and nothing in the line of local medication could be of service. Up to this time there has been no change in the deafness or tinnitus, except that the right ear can now distinguish the tick of my watch at a distance of about one inch.

LOUISVILLE.

## Societies.

### LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, February 1, 1889, J. M. Ray, M. D., Vice-President, in the chair.

Dr. W. L. Rodman exhibited a pathological specimen. He said:

This tumor was removed by Dr. Henry Pusey, and by his courtesy I show it and report the case. Mr. N., age sixty-nine years, living in Breckinridge County, Ky., sought advice of Dr. Pusey in October, 1888. He gave the following history: About twenty years ago a small, painless, moderately soft tumor made its appearance in the perineum between the left side of the scrotum and the inner side of the left thigh. It grew very slowly, and has always been freely movable under the skin. It has never been the seat of pain, though at times it has caused him some annoyance after riding horseback, it necessarily being pressed upon and irritated during such exercise.

I was asked to see Mr. N. in consultation with Dr. Pusey. We diagnosticated a benign tumor, and advised removal. The diagnosis lay between lipoma and soft fibroma—the location of the tumor favoring the latter. At one point the tumor seemed quite soft, as if fluid might be present. It was aspirated with a fine needle, but no fluid found.

The patient was not able to remain in the

city to have an operation performed at this time, and left, to return in a month. He returned more than three months afterward. He said that during this time the tumor had pained him some and had grown quite rapidly. He thought the aspiration was the cause. It had increased in size one third during the three months intervening between the first and second visits. There was no discoloration of skin, and the tumor was still movable. It was quite as large as a medium size orange. It was removed by Dr. Pusey under cocaine, the patient fearing chloroform.

The tumor was distinctly incapsulated. Besides its own capsule the deep fascia of thigh and perineum was very much thickened around the tumor, becoming indeed a second capsule. In this the blood-vessels were very large indeed, especially the veins. The tumor was attached above by a pedicle beginning at the left external abdominal ring. The vessels were larger and more numerous in the pedicle than elsewhere. The tumor with both capsules was entirely removed, for as soon as the outer one was reached both of us suspected sarcomatous infiltration, so vascular was it. Its history indicated a tumor practically benign in character, so we diagnosticated it as a soft fibroma run wild (that is, infiltrated with sarcoma elements, most likely small spindle cells) or what is known as the "Recurrent fibroid" or "fibro-plastic tumor of Sir James Paget."

This we know to be clinically a comparatively benign growth, sometimes not recurring after complete removal, again coming back once or twice, and then not recurring further as the soil is exhausted. Pathologically it is a small spindle-celled sarcoma.

Professor Cottell, to whom tumor was submitted for a report as to its microscopical appearance, confirmed the diagnosis.

If discussion follows, I wish two points considered: (1) Could the aspiration have had an unfavorable influence? (2) This man, being of sound constitution, and sixty-nine years of age, may he not live out his expectancy?

In regard to the first question I should say, that while such a thing is possible, and many such cases are reported, I do not think that it was so here. I rather think the tumor must have grown rapidly for some time before he consulted Dr. Pusey in October, otherwise a man sixty-nine years old, who had been carrying it for more than twenty years, would have continued to do so unless something had occurred to cause him alarm.

In regard to the second question, I answer, yes; for, while the tumor may recur, there is little tendency to affect the general health in this class of neoplasms.

The topic of the evening, Antipyretics, was introduced by Dr. William Bailey. He said:

Animal heat is maintained by the oxidation of tissue. Fever may be due to deficient elimination of heat as well as to increased production of it.

The existence of a so-called heat center, while not proved, is highly probable.

Antipyretic treatment of fever is not accepted as proper by all doctors, for some believe that fever serves a good purpose, or, in other words, is a conservative process, and hence is not to be interfered with. In the judgment of the speaker this is an erroneous theory.

The consumption of more material than is necessary to maintain normal temperature is wasteful, and especially is it needful to prevent excessive waste as occurs in the hyperpyrexia.

Exhaustion as a rule, other things being equal, is in proportion to the fever, or tissue change upon which the fever depends, and hence all high fevers should be controlled. It makes no material difference how the fever is produced, by inflammation, microbe or ptomaine, if above 103° F. it ought to be diminished. This question should interest the surgeon as well as physician.

It is not my purpose to discuss the peculiar virtues of individual antipyretics, but, instead, the principles of their use in therapeutics.

I will especially call your attention to this point. Is it not better to lessen tissue change

and save fuel than to lower the temperature by increased elimination?

This is like cooling off the apartment by opening the doors instead of shutting off the draft.

The condition of the coal-supply in the spring-time will very readily determine which method has been practiced.

I believe it wiser economy to use those individual antipyretics that influence the nerve centers, and thereby lessen tissue change, than to keep the fever down that is produced by tissue change by increasing elimination of heat.

I think that clinical observation shows that many patients bear the range of fever to 103° without serious detriment, yet few can bear for any length of time 104°, or above, without evident after prostration. If fever is conservative, then ought not prognosis be made more favorable by its elevation?

#### DISCUSSION.

Dr. J. B. Marvin: Two scholarly and ingenious contributions on this subject have recently been published, viz., a series of papers by Dr. T. J. MacLagan on "Pyrexia and Hyperpyrexia," and the Gullstonian Lectures "On the Nature of Fever," by Dr. D. Macalister. These gentlemen treat the subject from different standpoints, and their conclusions are not in entire accord, but they represent the outcome of physiological teaching on animal heat, and each suggests, according to their respective views, hypotheses more or less satisfactory in explanation of the nature of fever. Both start from the same premises, viz., that fever is essentially a disorder of body heat; that in health body heat balances heat loss, hence the stability of temperature.

Dr. MacLagan includes heat among the excretory products to be eliminated from the system at the same time and manner as urea and carbonic acid. He rejects Traube's theory that fever is due to retention of heat consequent on contraction of minute arteries. Such a condition, except in the initial stage, is inconsistent with the thermometric course of pyrexia. As a matter of

fact there is an increased elimination of heat in fever, due to heat acting as a stimulant to heat elimination. Increased formation of any product leads to stimulation and increased activity of the organ by which it is eliminated. Increased formation of heat gives rise to increased activity of the heat-eliminating function of the skin. Hence, before an attack of fever has lasted many hours or days, increased formation of heat is balanced by increased elimination, and no further rise of temperature occurs, though the fever process continues unabated.

*Example: Typhoid Fever.* A healthy adult gives off heat enough every half hour to raise the temperature of his body  $1^{\circ}$  C. Were heat to be formed uninterruptedly at this rate without elimination, the body would reach the boiling point in thirty-six hours, but, owing to balance between heat production and elimination, the temperature remains at  $98.5^{\circ}$  F. In fever heat production is greatly increased. Were elimination to remain as in health, there would be no limit to the febrile range of temperature. In fact, owing to increased elimination, and not retention, the temperature in pyrexia rarely goes above  $106^{\circ}$  F. Ord's hypothesis, that in the process of tissue formation heat is rendered latent, and is liberated in the febrile state, is rejected as inadequate to explain the excessive heat production that occurs—pure hypothesis. Dr. MacLagan draws a sharp line between pyrexia and hyperpyrexia. All pyrexia he explains in term of metabolism by the so-called combustion theory. Regarding heat as an eliminatory product in the specific fevers, the contagion consumes the store of albumen intended for the repair of the tissues and the water necessary for tissue metabolism, causing the tissues to consume their own substance for lack of replenishment from albumen and water normally intended for them, giving rise to increased elimination of excretory products, heat, urea,  $\text{CO}_2$ . Hyperpyrexia consists in temperature running from  $107^{\circ}$  to  $110^{\circ}$  F., or perhaps higher, with coincident development of alarming nervous symptoms, usu-

ally resulting in death by coma. Examples—hysterical, heat apoplexy, and rheumatic. The combustion theory is inadequate to explain these cases. The nervous symptoms are not caused by the hyperpyrexia, but are indicative of the nervous disorder which produces the hyperpyrexia. The neurotic theory explains these cases, as well as most ephemeral fevers and fever due to non-inflammatory lesions of the nervous centers.

Dr. Macalister gives us a new terminology and new conceptions, and places the pathology of fever in closer accord with modern physiological teachings. He makes no mention of the etiology of fever, nowhere refers to bacteria. He expands the neurotic theory to cover all forms of pyrexia. This thermotaxic mechanism is the highest and most essential of all the factors concerned in the maintenance of the body heat. It is the easiest deranged, and is the connecting link of all pyrexia. The nervous mechanism concerned in heat loss (thermolysis) is that of the vaso-motor and respiratory systems, each possessed of motor and inhibitory functions. The vaso-motor system is the great agency by which heat loss is regulated. Heat production (thermogenesis) takes place largely in the muscles, not dependent upon, but largely increased by their contraction. A nervous mechanism presides over thermogenesis similar to thermolysis. This mechanism is two-fold, one exciting thermogenesis, and accompanied by destructive metabolism; the other inhibiting thermogenesis, and subserving destructive metabolism. One is catabolic, the other anabolic; one motor, the other inhibitory; one exciting muscular contraction, the other relaxing the tissues. Thermogenesis is placed in the vital scale a little higher than circulation and respiration, and a little lower than voluntary muscular action. As yet there is but scant evidence of the existence of these thermal nerves.

Wood claims to have found a thermogenetic center near the crucial sulcus, and Aronsohn and Sachs find a heat-generating center near the inner side of the corpus striatum.

The thermal nervous system has three

parts—thermotaxic or adjusting, thermogenetic or producing, and thermolytic or discharging. Disorder of the first (thermotaxic) implies irregularity of temperature only; of the first and second (thermotaxic and thermogenetic) implies heightened temperature and increased body heat, that is, ordinary fever—of all three (thermotaxic, thermogenetic, and thermolytic) hyperpyrexia, dangerous increase of heat and steadily rising temperature. The three mechanisms are successively evolved as we ascend in the animal scale. Cold-blooded animals have little more than a thermolytic or heat-losing mechanism. Infants have only the thermogenetic and thermolytic, there being hardly any adjusting mechanism, as is shown by the instability of their temperature. Fever is a dissolution process. The last mechanism involved (the thermotaxic) gives way first, then the thermogenetic, and lastly the thermolytic. Conversely, when the patient convalesces, thermolysis is first restored to normal, then thermogenesis, then thermotaxy.

Those who believe in the germ theory in general believe in the beneficial nature of high fever. I do not agree in this opinion, but think, with Dr. Bailey, that if this were so, the higher the temperature the better the prognosis in fever. I do not use full cold baths, being satisfied with sponging at most. This, as the speaker says, does not lessen heat production, but increases heat elimination.

In regard to antipyretics, I am satisfied that acetanilide, or antifebrine as it is commonly called, is the safest and best of the list. It is cheap, quick in action, and the dose is small. I have seen no bad effects from it. Given discreetly, in high temperature, acetanilide does not produce too great depression; it slows the pulse and lessens the temperature.

Dr. Ap Morgan Vance said he did not pay as much attention to the thermometer as when he first had charge of surgical cases; then he thought it was the surgeon's best friend, now he regarded fever as an evidence of a failure of asepsis, as in a case of compound fracture, where failure has

followed an effort to convert the condition into a simple one. We have a perfect guide to the condition of the wound in the range of temperature. High temperature may be caused by complications in surgical cases; malaria, for instance.

Dr. A. M. Cartledge was much interested by the lucid remarks of Dr. Bailey on this very practical subject. His views materially differed from those of the essayist and Dr. Marvin as to the best means of controlling pyrexia and hyperpyrexia. He thought, with Dr. Marvin, that the theory of Macalister as to the mechanism of fever was the most acceptable yet put forth; however, it is wanting in the essential feature of an underlying cause for the disturbance of the so-called heat-producing, heat-regulating, and heat-discharging centers.

Eliminating the cases of neurotic origin, he believed the overcharging of the blood with micro-organisms the cause of fever. In treatment he would first attempt to lessen the blood impregnation, and secondly, as a means of combating fever, would use those agents which assisted heat elimination by natural or physical laws. He was opposed to agents which acted on the heat-producing center, such as antifebrine, antipyrine, etc.; believed they reduced temperature by their toxic effect, viz., by heat depression. The same is true of quinine as a simple antipyretic; no doubt it exerts worthy antipyretic virtues in its specific field. He did not believe in the theory that high fever favors the destruction of germs, and its logical deduction, "the higher the fever the better the prognosis." He thinks the height of the temperature to be the index of systemic poisoning under the action of micro-organisms.

Dr. D. T. Smith: I agree with Dr. Bailey, that whatever vital regulation the production of heat in the system may be subject to, the oxidation of tissue must be the ultimate source of practically all the heat in the body.

There is undoubtedly in the medulla a heat center controlling either directly or indirectly the production of heat, but no nerve center can create heat.

Nor is it necessary to suppose that microbes or other septic material in the blood are the cause of increased heat production, since we have learned, in those very experiments relied on to prove the existence of a heat center, that extreme hyperpyrexia may be produced almost instantaneously in the body by wounding the so-called heat center in the medulla. Very high temperature results also when the upper cervical spine is fractured and the cord injured.

I have also a theory of heat production and heat regulation. An important rôle in these processes I attribute to the leucocytes acting in conjunction with the nerves. I doubt if the term heat center, or even motor center is not a misnomer as applied to any localized part of the brain. These so-called centers are more likely executive stations from which messages gathered in all parts of the brain are sent out.

How can the leucocytes and the nerves gather heat? In the first place we will assume that the former seize upon and digest all particles of the system that have become separated from their nerve-supply—that are dead.

It is not at all certain that the leucocytes themselves do not receive nerve force. But whether they are controlled by the nerves or not, the nerves protect the tissues from their action until these tissues are ready to be supplanted by new.

I have said a nerve center can not directly create heat, but it may, perhaps, withdraw the arm of its protecting influence from the tissues and permit them to be seized by the leucocytes and broken up for oxidation. In this way, by surrendering half-ready molecules and cells to the leucocytes, the nerve centers may produce hyperpyrexia just as by surrendering the worn-out cells they produce normal heat. Antipyretics, then, might act in many ways: as a protoplasmic poison, paralyzing the leucocytes; as a tonic, strengthening the hold of the nerves on the tissues, or a relaxant of the peripheral vessels allowing dissipation of heat.

As to the remark of Dr. Bailey, that "if fever is conservative, its elevation ought

to make prognosis more favorable," I consider it logical fallacy; the conclusion does not follow from the premises. I do not assert that heat is not a good thing, only that the argument is fallacious. Not every thing that is good in some degree is good in every degree. Shock, for instance, is a wise provision of nature for the protection of the organism, but no one would say the more shock the better. If I am overcome by sudden emotion, if I receive violence, or am exposed to sudden cold in such a way as lowers the vital powers, nature comes to my aid with shock. My skin and my limbs can do better without warmth and blood than my brain and heart and other internal organs; therefore, when the vitality is lowered, the arterioles and capillaries are made to contract, so that the warm blood is retained for the internal organs till the powers are sufficiently restored to furnish the normal measure of heat. A little shock is a most beneficent provision of nature, but no one argues that the more shock the better.

As to the practical bearings of the question, there seem to me so many unascertained factors in the problem that we are to be guided by experimental results alone. I have not yet found the antipyretic medication that I would willingly give, or would take myself, if I were sick. Cold drinks, sponging, and cold water poured on the head have with me given better satisfaction than all the rest.

Dr. S. G. Dabney: Do antipyretics reduce temperature by lessening tissue change or by increasing radiation of heat from the body?

Dr. Bailey: In answer I will say that shock in surgery is no more favorable *per se* than is fever. If it is favorable, then why try to remove it? Because hemorrhage, etc., in injury is controlled by shock is no reason for believing that *per se* it is desirable. If you have two men injured just alike, and one has decided shock and the other little or none, you do not conclude that the prognosis is more favorable in the one the subject of the shock. In answer to Dr. Dabney and others, I will say that it is in proof that some of antipyretics

operate by lessening tissue change and not always by increased radiation. It is claimed by some authorities that such antipyretics as antifebrin, which usually produce fever diaphoresis, will yet lower the temperature even if opposed in their action upon the skin by atropia. Alcohol and others no doubt lessen tissue change as well as increase radiation.

S. G. DABNEY, M. D.,

*Secretary.*

## Reviews and Bibliography.

**Questions and Answers on the Essentials of Anatomy.** Prepared especially for Students of Medicine. By CHARLES B. NANCREDE, M. D., Surgeon to Jefferson College Hospital, etc. With one hundred and seventeen illustrations. Pages 352. Price, cloth, \$1; interleaved, \$1.25. Philadelphia: W. B. Saunders. 1888.

This is No. 3 of Saunders' Question Compend. Like the others of the series, it is not intended to supplant any of the textbooks, but to give the essence of the facts with which the average student must be familiar. For purposes of self-quizzing and for recalling or keeping fresh in mind the knowledge of anatomy gained under the favorable conditions supplied by demonstration at school, it would not be easy to speak of it in terms too favorable. It is truly such a book as no one can afford to be without who would not make anatomy a special study, and yet would keep himself fairly familiar with it.

D. T. S.

**A Compend of Human Physiology.** Especially adapted for the Use of Medical Students. By ALBERT P. BRUBAKER, A. M., M. D., Demonstrator of Physiology in the Jefferson Medical College, etc. Fourth edition, revised and enlarged. Pages 174. Price, \$1. Philadelphia: P. Blakiston & Son. 1888.

This compend of physiology is the outgrowth of the author's system of examinations in the quiz room during a number of years. As most students enter upon the study of physiology before they have acquired a thorough knowledge of anatomy, such anatomical details have been inserted

as seemed to be essential to an understanding of the functions about to be studied. This is also of advantage to those who would review physiology after their knowledge of anatomy has become somewhat obscure. The work is well executed, and possesses merit of a high order.

D. T. S.

**Questions and Answers on the Essentials of Surgery, together with a Full Description of the Handkerchief and Roller Bandages.** By EDWARD MARTIN, M. D., Instructor of Operative Surgery, University of Pennsylvania, etc. With ninety illustrations. Pages 314. Price, cloth, \$1; interleaved, \$1.25. Philadelphia: W. B. Saunders. 1888.

This is No. 2 of the excellent series of question compends now being issued by the enterprising house of W. B. Saunders. It is usually the case that students, in reading the standard works, are at a loss to discover the important points to be remembered, and so misdirect their efforts with loss of time. They are equally puzzled in attempting to formulate ideas as to the manner in which questions may be put in the examination room. The usefulness of arranging the subjects, as here, in the form of questions and answers, will be apparent. This work must be of very great value in preparing for examination or for the purposes of reference.

D. T. S.

**Hand-book of Historical and Geographical Phthisiology, with Special Reference to the Distribution of Consumption in the United States.** Compiled and arranged by GEO. A. EVANS, M. D., of New York. Pages 295. Price, \$2. New York: D. Appleton & Company. 1888.

In this volume the author presents a sketch of the growth of knowledge of pulmonary consumption from the time of Hippocrates to the present day, and also to arrange statistics in regard to the geographical distribution of consumption in the United States so as to make them available for convenient reference in selecting localities of resort or residence for invalids, and also for those who are in health.

When we consider in how few States trustworthy records are kept, we might at first

blush be disposed to pronounce the best compilation possible under the circumstances of very doubtful value; but when we compare statistics of cities, in the different States where they are well kept, with those in the country, and find them agreeing so well for any given district, we are forced to the conclusion that, however obtained, these statistics are not far from correct. From these figures the Carolinas, Texas, and the southwestern territories seem to exhibit the greatest immunity, while the New England States, with Kentucky and Tennessee, present the least. Aside from a few ill-favored localities, the figures show a startling uniformity, and indicate that immunity from consumption is nowhere found.

D. T. S.

**Questions and Answers on the Essentials of Obstetrics.** Prepared especially for Students of Medicine. By WM. EASTERLY ASHTON, M. D., Demonstrator of Clinical Obstetrics in the Jefferson Medical College, etc. Pages 220. Price, cloth, \$1; interleaved, \$1.25. Philadelphia: W. B. Saunders. 1888.

In this manual Dr. Ashton presents a judicious selection of all the most valuable facts to be found in the standard works on obstetrics. It proposes only to assist the student in mastering the essentials of the science and art of obstetrics, but the practitioner must be congratulated who will not find in its perusal abundant aid in keeping him prepared and ready for the emergencies of his calling.

D. T. S.

**Excessive Venery, Masturbation, and Continence: The Etiology, Pathology, and Treatment of the Diseases Resulting from Venereal Excesses, Masturbation, and Continence.** By JOSEPH HOWE, M. D., late Professor of Clinical Surgery in Bellevue Hospital Medical College, etc. Pages 299. Price, \$2.75. New York: E. B. Treat. 1888.

This volume, the author tells us, contains the substance of a course of lectures delivered in the Medical Department of the University of New York. We must be allowed to say that it would be a very high recommendation of a certain volume if it could justly be said of it that it contained the sub-

stance of this. This is happy in style and prolix in matter, and not at all attractive reading for the class who are usually regarded with so much compassion by authors, viz., "the busy practitioner." Still there are many good things in it, and the author's views, on the whole, merit commendation.

D. T. S.

**The Vest-Pocket Anatomist.** By B. C. HENRI LEONARD, A. M., M. D., Professor of the Medical and Surgical Diseases of Women, Detroit College of Medicine, etc. Fourteenth revised edition, containing one hundred and ninety-three illustrations. "Dissection Hints" and Visceral Anatomy. Pages 297. Price, \$1. Detroit: Illustrated Medical Journal Company, Publishers.

In this little volume the indefatigable and talented author has gathered in a condensed form whatever is to be found in Gray, and, in addition to that, has selected from the best points in the anatomical department of many of the best special works. It forms an excellent dissecting-room companion, as well as a useful article for the surgeon's case, as beyond the information he will find in its pages no emergency is likely ever to press him.

D. T. S.

## Correspondence.

### LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Causes of death occupy many pages of the Registrar-General's annual review for 1887. In that year it appears that in London the mortality from accident (properly bracketed with "negligence") numbered among males 1,637 deaths out of a total of 42,120, and among females 898 out of 40,184. This may be compared with the figures for the whole of England, which show 11,103 fatal "accidents" out of 272,137 deaths of male persons, and 4,415 cases of accidental deaths of females out of a total mortality of 258,621. A striking illustration of carelessness of infant life, especially in the metropolis, is supplied by those accident returns which apply to children under five. In

London more than half of the accidental deaths among males happen to children of this tender age, while the proportion in the case of females is rather over three tenths. In all England, however, the proportion, though large, is not so striking—males, 2,150 children under five in a total of 11,103; females, 1,712 in 4,415. Both in London and in all England diseases of the respiratory system claim by far the greatest number of victims. The nervous system is the next source of weakness with both sexes in all England and with the males in London, but among London women miasmatic diseases claim a few more victims.

A short time ago hydrofluoric acid was so much in vogue as a certain cure for pulmonary phthisis that several physicians claim priority for its introduction into therapeutics, and many ingenious appliances have been invented for inhaling it with safety. In a recent interesting brochure upon new methods of treatment, a copious appendix is devoted to the inhalation of hydrofluoric acid properly diluted with air and moisture. In spite, however, of the antiseptic properties of the fluorine compounds, recent experiments do not hold out, it appears, much hope for hydrofluoric-acid inhalations as a cure for phthisis. It is found that the effects of such inhalations are very slight indeed, whether the tuberculosis bacilli are in the economy or in appropriate cultivation liquids. Anyhow, the vapor of hydrofluoric acid is a very difficult agent to handle. In investigating its effects on rabbits which were consumptive, air which bubbled through a ten-per-cent solution of hydrofluoric acid in water was used, but the results were not at all satisfactory. The strength of the solution was then increased to forty and afterward to sixty per cent, but with no better result. The animals all died of consumption, and it became very evident that the hydrofluoric inhalations were useless. Yet a doubt remained because the virus had been introduced directly into the blood, while the medicated vapor could only come in contact with the lung tissue. Liquids containing the bacillus of

phthisis were treated with the medicated vapor, and then inoculated into the animals, but the results were little better, and the conclusion was arrived at that the experiments scarcely agreed with the observations published on the favorable results obtained in medicine, unless the indirect action of hydrofluoric acid on secretions and nutrition have a beneficial effect on the progress of tuberculosis in man. Several practitioners of note declare that, according to their clinical experience, hydrofluoric acid is at best an agent that increases the appetite and so may help in the successful issue of a treatment founded on some more trusty medication.

Some cases have been placed on record of the successful employment of antipyrin in cases of very severe ulcerated hemorrhoids. What first directed attention to the drug, as probably being of use in such cases, appears to have been a remark of Neudorfer that the antipyretic properties of the compound are secondary to its analgesic and antiseptic qualities, and that therefore the synonyms anodynin and asepsin are very appropriate. In some cases where all the usual remedies, including suppositories of cocaine, morphine or belladonna had been used with little or no relief, antipyrin, finely powdered and sprayed on to affected parts, acted with very beneficial results.

Mr. Butlin, in pursuance of his opinion that it is not necessary to remove the cartilaginous or bony frame-work of the larynx in certain cases of intrinsic carcinoma of the larynx which are suitable for operation, has reported two recent cases which have been under his observation. One was a case of squamous-celled carcinoma in a man aged fifty-one; the thyroid cartilage was divided in November, 1887, and the disease was cut and scraped out. The patient recovered without hindrance, and was soon well. The second was a case of the same disease in a woman aged twenty-seven. A similar operation was performed in 1888. She made a good recovery, and is now well and free from every sign of cancer. Mr. Butlin pointedly draws attention to the compara-

tively trivial nature of the operation in cases of malignant disease of the larynx of limited extent. In another instance in which he performed an exploratory thyrotomy in a man advanced in years, and found the disease too extensive for removal, he closed the wound, and the man recovered and left the hospital wearing a tracheotomy tube.

The doyen of the British naval medical service, deputy inspector-general of hospitals and fleets, Robert McCormick, R. N., F. R. C. S., of Hecla Villa, Wimbledon, will enter on his ninetieth year, should he live till next July. Besides being the oldest surviving naval medical officer, he is the Nestor and Homer of Arctic explorers. An interesting biography of him appeared under the heading "Celebrities at Home," in the issue of the World, November 28, 1888.

At the Royal Infirmary, Newcastle, a case has occurred of the primary union of an unsutured wound of the bladder made while performing suprapubic lithotomy on a boy. After the removal of a stone from the bladder the vesical wound was not sutured, but the skin wound was closed with a continuous catgut suture, a small drainage-tube being left at the lower angle; a soft rubber catheter was secured in the bladder. Four days afterward the wound was examined for the first time; it was healed and the dressing quite dry. The drainage-tube was removed, and on the seventh day the catheter was permanently withdrawn and the boy allowed to pass his urine, which he did without inconvenience. The child was able to leave the hospital on the tenth day, and might have left earlier.

In the new edition of Holmes' Surgery the chapter on diseases of the eye has been omitted, on the ground that this department of surgery is now so extensive and has been so much modified by recent discoveries that it could only be taught by one actively engaged in ophthalmological practice, and even then very inadequately in the limited space which alone could be devoted to it in such a work.

A new surgical soap is recommended as an antiseptic soap for general use in the

hospital and for private practice. It is made of the following ingredients: Oil of sweet almonds 72 parts, soda lye 24, potash lye 12, sulpho carbolate of zinc 2, scented with otto.

LONDON, JANUARY, 1889.

## Translations.

UNDER THE CHARGE OF J. N. BLOOM, A. B., M. D., DERMATOLOGIST TO LOUISVILLE CITY HOSPITAL, ETC.

PROF. ZIEMSEN ON THE TREATMENT OF TYPHOID FEVER.—(*Memorabilien*, Heft 4, 1888.) Ziemssen ascribes the diminution of the mortality to the improvement in therapy. He does not think that this disease now appears in a milder form than formerly, although it does appear much less frequently.

The principal factor in the therapeutical diminution of the mortality he considers the water treatment, in its widest sense, not the cold water alone, and with it increased attention to hygiene and diet. He abhors an indifferent or expectant treatment.

The sick bed should be well arranged, the room, if possible, large, well ventilated, and quiet. Water pillows are best, and a second bed in the same room, so that the patient can change occasionally, is of advantage. A good trained nurse is preferable to "family" nursing. As to the diet, even during the fever, easily digested albuminoids should be allowed. Freshly prepared expressed beef juice is best, and five to seven ounces should be given daily. As to other articles of diet Ziemssen follows the views of most other writers. According to Rank's estimate, the diet of the patients in Ziemssen's clinic consisted of 91 parts of albumen, 76 parts fat, and 100 parts carbohydrates. The large quantity (relatively) of albuminoids is of great advantage to the limitation of the destruction of organic tissue, and is shortening the period of convalescence. Calves' foot jelly with wine is given frequently. Few medicines are given, and only when special indications for them exist.

Calomel has a decided effect when given at the right time, that is, during the first five days of the disease. The dose is 8 grains (fifty centigrams) given three times in two hours.

In order to determine the temperature of the bath and its indications, the temperature of the patient should be taken *per rectum* every two hours; two or three minutes suffice for its determination. Begin with a bath of fifteen minutes' duration and a temperature of 82° to 86° F. (22° to 24° R.) The higher the temperature and the severer the brain symptoms, the colder the water, but never colder than 62°F. (14° R.) The writer lays special emphasis on cooling the bath off gradually. Young and robust patients can be placed at once in a bath of 62°-64° F., but not lower, and seldom as low. "The more recent the case, the higher the fever, the more robust the constitution, the cooler the water; conversely, the more advanced the case in point of time, the weaker the constitution, the worse the pulse and the more affected the nervous system, the warmer the bath." Adynamic symptoms are no contra-indication for bathing, but the baths should be warm—up to 86° F. The number of baths average three or four in twenty-four hours. Sometimes one or two suffice, sometimes six or eight are necessary. *The baths are most efficacious at the periods of remission of temperature.* The duration of the bath should be fifteen to, at the most, thirty minutes.

The antipyretics, of late somewhat fallen into discredit, are defended and recommended by the writer, especially antipyrine, which he gives as follows: Five grams (75 grains) are given after six o'clock in the evening, two grams (30 grains) followed in one hour by two grams (30 grains), followed again in one hour by one gram (15 grains.) He praises thallin and antifebrin, but does not think much of quinine, because of its after-effects, not so much the deafness and tinnitus as the "general indescribable *malaise*, especially that referred to the abdominal region." Besides the antipyretic action of the above-named drugs, they are valuable for the euphoria which they produce. Kairin and salicylate of soda, as antipyretics, he regards as antiquated.

Brain symptoms of moderate degree call for ice-bags, which, however, are not tolerated by some patients. When the cerebral symptoms are severe, baths are absolutely essential. Insomnia and restlessness are best treated by

morphine injections. When there is a tendency to cardiac weakness, excitants are indicated, the best of which is camphor (one half to one dram sub-cutaneously as oil of camphor) and wine, cognac or champagne.

Severe diarrhea he treats by clysters of starch and opium (20 drops of laudanum;) intestinal hemorrhages, by ice-bags on the belly and ice clysters, which are efficacious by reflex action; no nourishment is given for several days, and thirst is slaked with ice. "Hemorrhages during the period of delayed convalescence (four to six weeks) are of much worse prognostic meaning than those which follow the detachment of the slough (two to three weeks), because it almost always indicates delayed healing of the ulcers, and a scorbutic condition of the edges of the same." Bed-sores can be avoided with certainty if extreme cleanliness and proper position be observed, and, besides baths, a water pillow be used.

During convalescence particular attention must be paid to diet; for five days after the first day without fever, only liquid nourishment should be given; then only should semi-solids be indulged in, to be followed by solid substances. At this period the patient thinks of eating only, and we must give him daily something new and appetizing. The patient should not get up until the fourteenth day after the disappearance of the fever, however light the attack may have been. If the attack was severe, he should lie abed for three or four weeks after the apyretic stage has set in.

The treatment of exacerbations should be the same as indicated, except that they can be much milder. Lukewarm baths act sufficiently well, and antipyretics may be dispensed with.

• PARTIAL RESECTION OF THE SYMPHYSES AS AN AID TO OPERATIONS ON THE BLADDER. (Prof. Helferich, *Arch. f. Klin. Chir.*, p. 625, 1888; *Schmidt's Jahrbuch*, No. 11, 1888.) The object of the operation is to allow more room in operative procedures, and it is indicated where malignant tumors of the bladder are to be operated upon in the radical treatment of hypertrophy of the prostate, and in the removal (supra-pubic) of unusually large calculi, or such as are included in diverticula. The

operation requires neither great skill nor much time. Partial resection has no bad effect on the firmness of the pelvic arch and ring, and adds much to effect an easy entrance to the bladder. If the symphysis is divided into two equal portions by a horizontal line at its middle point, this line will, if prolonged, reach the foramen obturatum. The upper part of the symphysis can be removed, and a large portion of the bladder is exposed; it does not lie so deeply and operations are much facilitated. Total resection should only be practiced in extraordinarily difficult operations.

### Abstracts and Selections.

**CASE OF GANGRENE OF THE TRANSVERSE COLON IN AN UMBILICAL HERNIA; REMOVAL OF TWENTY-TWO INCHES OF GUT; SUTURE OF THE INTESTINE: RECOVERY.**—In the spring of the present year I mentioned, at one of the meetings of the Medico-Chirurgical Society, the case of a patient from whom I had removed a large piece of gangrenous transverse colon. The patient recovered from that operation with an artificial anus at the umbilicus, and I said that I hoped to complete the cure by some further operation, and report the case more fully at a later date. Accordingly, this evening I propose to read a short history of the case from its commencement, and to discuss briefly such points of interest as suggest themselves.

Mrs. R., aged thirty-eight, was admitted from the Maternity Hospital into Ward VIII of the Royal Infirmary, on 14th April, suffering from umbilical hernia. The previous history of the case was to the effect that the patient had suffered for seven years from an umbilical hernia of large size, which, however, had never given any trouble till ten days before admission. At that time the patient reports that she took a long walk, that the streets were slippery, and that she fancied she had strained herself by recovering herself in slipping. When she reached home the rupture was swollen and painful. Fomentations were applied, but as in a week's time she was no better she sent for her medical attendant. At this time Mrs. R. was seven months pregnant, and as no success followed the attempts at taxis, a firm binder, which the patient was in the habit of wearing, was reapplied, and she was sent to the Maternity Hospital, as it was feared she was about to miscarry.

The patient herself was under the impression that the child had been dead three or four days. At the Maternity Hospital no improvement took place, so she was transferred to Professor Annandale's wards in the infirmary, of which I happened to be in charge at the time.

On admission the following notes were taken: The patient is a strong-looking woman, but enormously fat, being some eighteen stone weight. At the summit of a large fat abdomen, distended by a uterus seven months pregnant, is a bright red, angry-looking, brawny swelling about fourteen inches in diameter, and projecting some four inches from the general outline of the abdominal profile. The patient is anxious and in pain, and the face is pinched. Pulse, 110; temperature, 100.2°. No vomiting had taken place before her admission to the infirmary, but as it came on a few hours afterward, I was sent for. I found that she had vomited about six ounces of a coffee-colored fluid containing blood; her pulse and temperature were rapidly rising, and she was evidently getting much worse.

I accordingly determined to operate at once, and with the assistance of Dr. Hodsdon and Dr. George Keith I freely opened up the swelling by an incision some ten inches in length. When the sac was opened it was found to contain a large coil of gangrenous transverse colon, several large masses of omentum adherent to the sac and also gangrenous, and fluid feculent matter which had escaped from the ruptured gut.

There appeared to be no strangulation at all at the umbilical opening, and the gangrene seems to have been caused by the pressure brought to bear on the contents of the hernia between the firm binder above and the pregnant uterus below.

We proceeded to cut away fifteen inches of colon which was absolutely gangrenous or beyond recovery, cleared out the putrid omentum and most of the sac, and, having washed the wound out thoroughly with sublimate lotion, stitched the cut ends of the gut to the edges of the skin wound, and got the patient back to bed in an apparently dying condition.

I will not detain you by a detailed account of the fight between life and death for the few days following the operation, how a condition of profound collapse, as evidenced by a fluttering pulse of 160, Cheyne-Stokes respiration, and delirium, gradually gave way before assiduous treatment. On the second day after the operation the bowels moved through the wound for the first time.

On the day following, that is, 17th April, the patient miscarried. A seven months' child was born alive with one pain, the whole labor being over in the course of three minutes. The child survived about two days. The bowels were again freely moved during the labor, and there was considerable *post-partum* hemorrhage.

The patient seemed to be considerably relieved by getting her labor over, and all went well with her till 20th April, when, after a severe rigor and rise of temperature, she developed an attack of phlegmasia dolens, first in the left leg, and, a few days subsequently, in the right. This, however, ultimately cleared up, and she left the hospital on 23d June with the wound well contracted and healed round the artificial anus. The bowels at this time were acting loosely about six times a day, and she was in very good health.

During the three months that she was out of the infirmary she was confined a good deal to bed, for there was considerable prolapse of the intestine and discharge of feces whenever she walked about much. Her discomfort was so great that she expressed a very strong wish to come back and have the artificial anus cured at any price, for, as she expressed it, "she would much rather die than go on as she was."

I had thought of trying to close the artificial anus by some modification of Dupuytren's operation, but was dissuaded from this by finding that fluids injected from the umbilical opening into the lower segment of gut would not pass *per anum*, but regurgitated alongside of the syringe. This appeared to be due to a kink in the gut at the splenic flexion about eight inches from the cut end, which kink was presumably caused by the dragging of the gut downward toward the late umbilicus. The patient was accordingly prepared for the operation of resection of the gut and suturing of its free ends. For ten days previous to operation she was directed to be fed entirely on peptonized fluids, partly by the mouth and partly by the bowel, and the intestines were still further emptied by castor oil and several enemata both from the umbilical opening and from the anus proper. This last proceeding resulted in the passage of a scybulous mass of large size *per anum*.

The operation was performed on 30th September, and again I had the assistance of Drs. Hodsdon and Keith. Having carefully cleansed the skin around the opening, and having washed out the two cut ends of intestine, I put a ligature round the upper

one to prevent feces escaping into the wound, and I then freed them both from the adhesions which bound them to the umbilical ring and surrounding parts. Gentle traction was then made upon the two ends until normal gut covered by peritoneum protruded sufficiently for my purpose. Instead of using a clamp I passed a piece of thin india-rubber tubing through a small hole in the mesentery and round the gut, fixing it there with a pair of catch forceps; I then cut away four inches of the upper segment of colon and three inches of the lower, with portions of mesentery attached. The two pieces of intestine were, as usual under such circumstances, found of very unequal size, the upper segment admitting four fingers, while the lower, in which function had been in abeyance for five months, would only just admit the forefinger. Though I succeeded in dilating it a little, this inequality in the two ends added very greatly to the difficulty of the operation. This difficulty has been got over in one or two cases by cutting the lower bowel away obliquely from its mesenteric attachment so as to increase the area to be sutured. By the very careful passage of over a hundred stitches I was able to get the ends satisfactorily together.

I used fine curved needles, round like a dressmaker's needle, and threaded with the finest Chinese twisted silk. The method used was the modification of the Lembert suture by Czerny, that is, a double row of interrupted sutures, which lie completely outside the bowel, and are passed through the serous and muscular coats of the intestine alone. The outer row is about one third of an inch outside the inner row, and the stitches of one row are about a line distant from one another.

The cut edges of the mesentery were then sutured together, and the gut was returned into the abdomen. The large umbilical opening was brought together by deep silk stitches, and a firm pad and binder applied. A hypodermic injection of one fourth of a grain of morphia was given, and the patient was put back into bed, having been just three hours on the table.

During the first twenty-four hours after the operation there was a little fever and restlessness, the temperature once rising as high as 102°, but in a day or two it became practically normal, and has remained so ever since. Wind passed freely the day after the operation, and the day following there was a free liquid movement of the bowels. From that time she has made an uninterrupted recovery, the bowels moving

about every other day. She was fed exclusively on peptonized fluids for three weeks after the operation, but for the last six weeks has taken soup, porridge, minced chicken, etc., and is now taking ordinary diet. There has never been any pain beyond a little occasional griping from the passage of wind along the bowels; but that has now quite ceased. A little compound liquorice powder is taken every two or three days to keep the stools soft.

She was discharged from the infirmary on 25th November in excellent health.

Without attempting to generalize from so small an experience, there are certain convictions which have forced themselves upon me in connection with this case.

First, that it is of the utmost importance, even in the case of a surgeon who is frequently operating, that this operation should be practiced on the dead body before trying it on the living. The confidence that one has really closed the gut, and the celerity in operating which are obtained by such practice, can not be too highly valued, for one can not test by any means on the living body whether the sutures have been applied in such a way as to render the gut watertight before it is returned into the abdomen; and it is most important not to waste any time in the performance of an operation which is very tedious at the best.

Again, judging from several hours' practice of the operation, I can not say that I see the necessity for the introduction into the lumen of gut of any of those materials, such as india-rubber collapsible bags, lumps of cocoa-butter, etc., which have been used for the purpose of dilating the gut during the process of suture. As a matter of fact, I believe that most surgeons who have had any experience of the operation are now coming to this opinion.

With regard to the clamps which are recommended for this operation, though I had the two most frequently used (Bishop's and Treves's) by my side. I used neither of them, as they appeared to hamper one's movements very considerably, and neither of them were long enough in the blade to efficiently clamp the large intestine. The piece of india-rubber tubing, applied as I have described, acted admirably. The best form of clamp appears to be that of Mr. Makins, of St. Thomas' Hospital. It is less complicated and cumbersome than the others, and has the advantage both over the method I used and over Treves' clamp, that no wounding of the mesentery is necessary for its application. This is somewhat important, as the

experiments of Rydygier and Madelung go to show that separation of the gut from its mesentery is apt to be followed by gangrene of the bowel at the denuded part.

The idea that an assistant's fingers should take the place of a clamp does not commend itself, for neither would the control of the gut during a long operation be so reliable, nor does this plan leave the operator so much room to work in, unless more healthy intestine is pulled out of the abdomen than would be necessary if a clamp were used.

I was prevented upon the occasion of the first operation, by the extreme prostration of the patient and the intense putridity of the parts concerned from suturing the gut and returning it into the abdomen at once.

It has been established, chiefly by statistics drawn up by Mr. Makins that the best results after resection of intestine are obtained in cases of operation for the cure of artificial anus (the mortality in this class being thirty-eight per cent as contrasted with a mortality of about fifty per cent when all cases are taken together). In other words, it appears less hazardous to do the operation in two stages rather than to complete it at the time of the removal of a gangrenous portion, when the patient is frequently in an unsatisfactory condition, both locally and generally, for such a serious proceeding. It is, of course, undeniable that the patient has in the former case to undergo two operations instead of one in the latter; but it seems probable that this apparent disadvantage is in some instances, at any rate, more than counterbalanced by the lessening of the mortality after the operation when it is done at the later stage. Upon the other side must be borne in mind the increased difficulty in the secondary operation due to the shrinking of the lower disused portion of intestine.

Of the thirty-three different methods of suture which have been recommended for the purpose, the one I employed, namely, Czerny's modification of Lembert's, is most in favor. It certainly appears to fulfill the chief requirement of bringing two broad surfaces of the peritoneal aspect of each segment in good apposition with one another, and, judging from experiment on the dead body, the double row of sutures is evidently of service in preventing the immediate escape of fluids from the sutured bowel.

A study of the reported cases of resection and suture of intestine shows that while a certain number of successful operations have been performed on the small intestine, chiefly by German surgeons (and among others by

the late Dr. Angus Macdonald, who, in the course of an operation for ectopic gestation, removed some six inches of small intestine), the large intestine has very seldom been successfully dealt with in like manner.

Mr. Hardie (Medical Chronicle, January, 1885) reports a case where he resected three inches of colon for artificial anus with a successful result. Mr. Kendal Franks has, within the last few days, published a case in which he successfully removed a large epithelioma with six inches of colon; and Professor Weir, of New York, informed me, a few weeks ago, that he had in one case resected six inches of colon with a good result.

In the case I have brought before you, no less than twenty-two inches of large intestine were removed in the course of the two operations.—*Mr. J. M. Cotterill, Edinburgh Medical Journal.*

SIR MORELL MACKENZIE ON THE TREATMENT OF ACUTE AND CHRONIC TONSILLITIS.—On Tuesday, December 4th, Sir Morell Mackenzie visited the throat clinic at the Edinburgh Eye, Ear, and Throat Hospital. He examined a number of the patients, and in the course of a short clinical lecture made the following remarks:

There are two forms of acute tonsillitis, the superficial and the deep. All of you must be well acquainted with these familiar diseases, but perhaps you will like to hear my experiences of the treatment. The superficial is not very serious; it is, however, painful, and it is apt to recur; a person who has had it once is very likely to have it again. This is true of both forms of tonsillitis, but is particularly so of the superficial. The interior of the follicles becomes inflamed and secretes an unhealthy mucus, and they never thoroughly recover. In all inflammations of mucous membranes the membrane does not really get well, though it may appear to do so. A celebrated French surgeon has said that he does not believe that a person ever really recovers after a gonorrhea. This is true of the follicles of the throat. A person who has once had acute tonsillitis never really gets well, though he may appear to do so. The treatment, therefore, is important. One of the most popular remedies is aconite—originally, I believe, a homeopathic drug, but now used extensively by allopaths (though I object to the term)—and strongly recommended by Dr. Ringer. It has certainly never, in my hands, proved to be of the extraordinary value which he asserts. On the other hand, I have found guaiacum, which used to be given in the form of the ammoniated tincture, very efficient. I recollect a Manchester surgeon,

Dr. Crompton, who used to come a good deal to the Throat Hospital about the time it was founded, telling me I should find much more benefit in giving it in the form of a powder; and I did so, letting the patient take a pinch of the resin. This was rather disagreeable, and after a time I had it made into lozenges containing about three grains in each. In this form it makes an excellent remedy. Nine cases out of ten will get rapidly well if one of these lozenges is given every two hours at the outset. I sometimes also apply locally a little bismuth and opium, or an eighth of an grain of morphia with a quarter of a grain of starch, because the problem is not only to cure the patient, but to keep him comfortable till he is cured. Sometimes the guaiac causes a little diarrhea, which is not altogether disadvantageous, but the morphia is usually sufficient to check it. What I have said about guaiac applies to acute inflammation of any part of the back of the throat. Dr. Home has said of guaiacum, "*Instar speciei in hoc morbo operatur.*" It is really specific. I have used it for fully twenty years, and I assure you it is one of the best remedies you could have. It causes a slight stinging sensation, and this is an additional reason for using the morphia.

Occasionally this superficial or follicular tonsillitis, if not checked, passes into the deep or parenchymatous form, and the structure of the gland becomes very much affected. When the deep inflammation occurs you must bring it to an abscess as quickly as possible, and open it. Trousseau has pointed out that some inflammations *begin* in the deep part of the gland, and these you can't check, as a rule, though you may sometimes succeed with guaiac. I have done so in two cases lately. We are usually, however, called in too late. When you find you can not stop the disease, give inhalation of benzoin, hop, or conium, and apply poultices to the outside of the throat. Directly you can see fluctuation, make an opening. As the tonsillitis develops it prevents the patient opening his mouth, and there is some difficulty in getting at the abscess. This is the reason why surgeons sometimes have to let the abscess burst, but this should be avoided, if possible, because it has been followed by dangerous and even fatal hemorrhages. I generally use a curved and guarded bistoury, of which only the last quarter of an inch has a cutting edge, but an ordinary bistoury, the greater portion of the edge of which is covered with diachylon, may also be used. The incision is made with the cutting edge directing inward to the center of the mouth. You must never cut outward, for there is then the danger of wounding the carotid. I would recommend you to incise in cases

in which you may not be quite certain of fluctuation. A slight puncture, even if pus is not evacuated, does no harm. The use of leeches was at one time common, but Louis the French physician proved that they did not cut short the disease by more than one day, and therefore their application was not desirable. Leeches have the effect of increasing the inflammation rather than otherwise if less than six are applied.

Chronic tonsillitis, or hypertrophy of the tonsils, proceeds from two causes. A large number of the cases are the result of a low form of inflammation occurring in childhood. The structure in childhood is very prone to become inflamed. If the tonsils are considerably enlarged, it is important to remove a portion of each. You should never speak of "cutting out the tonsils," as this sounds very alarming to the patient and his friends. Say that you mean to remove only "the diseased and enlarged portion." It is a consideration, when you should do this, how much enlargement should there be before the operation is performed? First of all, the question of size is entirely relative. In a large throat the tonsils may grow to a considerable size, and the patient still do quite well. In a smaller throat this would not likely be the case. If the tonsils touch each other you can have no doubt as to the propriety of taking away a piece. If adult patients come to you with the tonsils slightly enlarged, it is an important question whether you should cut off a portion or not. If the enlargement is associated with frequent attacks of acute inflammation, you ought then to cut away a piece. There is another condition which requires a similar proceeding. When the follicles of the tonsils are much enlarged, you can not cure it except by taking off a section, which may be not more than one eighth of an inch thick. You thus clear away the walls of the deep follicles and get a flat instead of a "worm-eaten" surface. As to the method of operating, many surgeons do it with a bistoury, and Sir William Ferguson, a great surgeon, for whom I had the greatest admiration, used to perform it in this way; but it was terrible to see the patient struggling with the mouth half full of blood before the operation was completed. Great surgeons will do all they can with a knife instead of what they call a "machine." I always perform the operation, however, with a "machine," a tonsillotome. The particular form I use is a modification of Physick's. The great advantage of this is that its mechanism is quite simple, and my modification enables the handle to be fixed on either side of the blade, so that the operation may always be performed with the right hand if the

operator desires. As a general rule lightness of touch is the chief desideratum in operating, but in tonsillotomy it is the reverse. Heaviness of touch is the important thing. The tonsillotome must be pressed well over the tonsil, which is also to be projected into by pressure with the left thumb placed under the angle of the jaw. I once had a colleague who could do very little else, but he took off tonsils marvelously, and as I watched him I observed that it was this heaviness of touch that made him so successful. If you don't attend to this you will not take off nearly so much as you desire. Patients have come to me, a week or a fortnight after the performance of the operation by another surgeon, saying that the tonsil had been removed but has grown again! This of course means that enough was not removed at the operation. It is most important to take off enough. Hemorrhage from this operation is rare, but it has occurred, and the carotid in some instances has had to be tied. I once had a serious hemorrhage to deal with some twenty-five years ago. The usual styptics, and even the cautery failed to relieve it. At last I tried a remedy which I have used ever since with perfect success. A chemist had informed me, a short time before, that a small quantity of gallic acid would prevent tannic acid dissolving. I mixed two parts of the tannic and one of the gallic in a little water, and gave the patient two teaspoonfuls, telling him to sip them slowly. The bleeding stopped almost at once. We have since used the same preparation at the Throat Hospital, and always with perfect success. The patient must be told to swallow the liquid, not gargle. Application with a brush will do no good. He should swallow the fluid slowly as if it were difficult to get it down, and must on no account wash out his mouth or gargle.—*Dr. J. M. Ross, Edinburgh Medical Journal.*

THE MEDICAL TREATMENT OF PERITONITIS. Not content with having made a vast stride forward during the past few years, abdominal surgery brings with it not only new methods of treating diseases in this region by the knife, but also has given us a method of healing peritonitis by the use of saline purgatives, which is certainly of the greatest value in these sudden inflammatory conditions which occasionally spring into life after operations upon the abdominal area. It will be remembered that Mr. Lawson Tait has been the chief advocate of this treatment for several years, and that the wonderful results which he obtained, the reputation of the reporter, and the complete reversal of all our ideas concerning the

treatment of the disease, have called forth not only an enormous number of trials of the method in this country, but have also brought forth two opposing factions in the profession. The first of these is chiefly composed of surgeons, the second of persons, who in a long experience have reached good results by older methods, and who are generally physicians. The first class dogmatically assert that the physician should turn over every case of peritonitis to the surgeon to be opened, searched, and purged; the second class do not deny that saline purgatives do good in the hands of the surgeon, but are more conservative in their opinions concerning the general use of such measures in all cases of peritonitis.

Again, it would seem to be impossible at the present time to assert that peritonitis may be either idiopathic or traumatic without bringing upon one's head a storm of criticism, for on the one side we have a number of physicians who believe that peritonitis may arise without any direct exciting cause, and, on the other hand, an equally large body of observers who assert that it is essentially a secondary inflammation brought on by direct contiguity with an already inflamed tissue, or else that the inflammation is set up by the escape of foreign bodies into the peritoneal cavity, or by pathological changes occurring in organs normally situated in these regions, as, for example, fibroid enlargements of the uterus with impaction in the pelvis, or pyosalpinx.

As it is absolutely impossible for either side at present to prove that their opponents are entirely wrong, and as both sides are not to be doubted in the integrity of their observations, the unbiased judge can but come to the conclusion that as yet we have a right to believe that idiopathic peritonitis may exist.

If those observers are correct who believe that no peritonitis arises save as the result of some one of these conditions, then the attempt on the part of the physician to treat such a case is criminal negligence, and such a practice can not be too severely condemned. But too many cases of peritonitis are to-day walking examples of the value of the use of opium to permit of any one asserting that this treatment is useless, or that the knife of the surgeon is to be used in every case, yet some of the more positive members of the profession would have us believe the abdomen should be opened solely for the purpose of making a diagnosis, and that, this having been done and no intestinal complications found, salines be given.

Whether the inflammation be idiopathic or not has little to do, however, with the methods which we are to resort to in the medical treatment of this condition. It can not be gainsaid that the results obtained by surgeons in the use of saline purgatives have been startlingly brilliant, neither can any one deny that their methods may sometimes be employed in medicine as well as in surgery; but there are several points to be recalled by both parties which, we think, so seriously modify the views of each as, after all, to unite them in a bond of unanimity. No one denies that the surgeon does rightly when he uses salines to prevent peritonitis after an operation, but the knowledge of the condition of the patient after he has been operated upon by the surgeon and that possessed by the physician when called to see a case of peritonitis are radically different; for the surgeon has a right to believe that the intestinal canal is patulous and devoid of impactions and intussusceptions, while the latter knows not whether he has before him an inflammation of the peritoneum without intestinal involvement or inflammation dependent upon some abnormality in the *prima via*. As a consequence it is perfectly proper for surgeons to administer salines which, to use their own words, not only deplete the abdominal blood-vessels, but also by the increased peristaltic movements produced prevent adhesions, while the physician in the case of peritonitis from perforation, impaction, or intussusception, may do the patient an immense amount of harm by such a procedure long before it is possible to decide what the cause of the trouble may be. It is evident, therefore, that the opium treatment must be adhered to, at least until the diagnosis is formed, unless at the very first sign of pain an exploratory incision is made instead of using those remedies generally employed in ordinary attacks of abdominal discomfort; and it should not be forgotten that pain and tenderness with inflammation are the symptoms of peritonitis, not only after section, but also of many other states in the ordinary individual.

It is also evident that other conditions may exist which render the administration of purges unjustifiable, and in which the use of the knife by the surgeon is not to be thought of. It is undeniable that the surgeon should be summoned the moment a suspicion of perforation arises; but in the case of a person in whom an enteritis has arisen locally by an old adhesion, increased peristaltic movement is equivalent to strap-

ping the normal side of the chest in pleurisy with the object of giving the diseased side more exercise.

Again, it is of the gravest importance that both the physician and surgeon should distinguish very clearly between an inflammation of the peritoneum in a strong, healthy person and in one who is in a condition of vital depression or exhaustion from prolonged disease elsewhere. Depletion by means of purges is, of course, in the first class as much indicated as the application of leeches or bleeding, but in the second class is quite as strongly contra-indicated. In the dynamic form of inflammation—there is danger of adhesions being formed by reason of the fibrinous exudate thrown out; in the adynamic condition of inflammation there is already an enormous exudation of serum into the abdominal cavity, which purges can not remove till they have drained off a large amount of liquid from the blood.

Again, there are some cases of peritonitis which are ushered in by an acute paroxysm of pain, but which do not continue during their whole course as dynamic cases, and in which depletion at first results in exhaustion later on.

Until the profession have employed these two methods side by side, with an absolutely unbiased opinion, for a long period of time, the only proper conclusion to be reached seems to us to be this, namely, that in acute peritonitis, suddenly lighted up in a surgical case, and which is recognized almost at the moment of its birth by the ever watchful surgeon who is on the lookout for it, the use of salines, by their rapid and complete depletion, may abort an attack; whereas, in the case which the physician rarely sees till hours have elapsed, and in which grave doubt must exist as to the cause of the trouble, opium and external methods of depletion must be resorted to.—*University Med. Magazine*.

**THE ACTION OF CHLOROFORM WATER AS AN ANTISEPTIC AND GERMICIDE.**—In the *Deutsche Medicinische Wochenschrift*, No. 16, 1888, Salkowski reports the results of studies which he has made upon this subject. It has been common-stock knowledge with most of the profession for a number of years, that chloroform-water added to urine prevents its decomposition, and, also, that chloroform prevents all those fermentations which depend upon the growth of micro-organisms, as, for example, the fermentation of yeast, the ammoniacal fermentation of urea, and the conversion of hippuric acid by fer-

mentation into benzoic acid and glycecol. It is also to be remembered that chloroform has in reality no power in the prevention of fermentation, the result of the action of such ferments as ptyalin and pepsin.

Salkowski has found that, by the addition of a little chloroform, milk may be kept in a well-corked bottle for months, keeping its alkaline reaction, and finally changing to a jelly which, upon shaking, separates into two layers, one of which consists of a clear yellowish fluid, the other being made up of casein and fat. Meissner has attempted to explain this gelatinous change, which occurs in sterilized milk, as being due to the action of a slowly acting milk curdling ferment. It has also been found that both cane and grape sugar do not ferment when yeast is added to them, provided chloroform is present; and the still more interesting fact is noted that nevertheless, in twenty-four hours, cane sugar is changed to invert sugar by some unknown ferment from the yeast.

Salkowski has also determined that albuminous liquids and meat will remain free from organisms if in the presence of chloroform, and that under these circumstances no growths can be developed on nutrient media.

It is also of interest to learn that chloroform not only prevents the growth of micro-organisms, but also destroys them, even though their development is extraordinary, for, if it be added to putrefying beef tea or applied to silk threads impregnated with anthrax bacilli, both rapidly become innocuous, the beef tea being sterile at the end of an hour, and the anthrax bacilli becoming innocuous after twenty-four hours; again, crushed spleens from animals suffering from splenic fever are rendered completely innocuous after thirty minutes' exposure, and the comma-bacillus of a fresh cholera cultivation mixed with an equal volume of chloroform-water becomes sterile in sixty seconds. It was also found that when guinea-pigs were inoculated with half a Pravaz's syringeful of fluid, composed of one drop of anthrax blood and eight cubic centimeters of sterilized water, death ensued in the course of two days, whereas in those instances where chloroform water was used with anthrax blood the animals remained healthy.

There are several practical advantages to be gained by the physician from this research, for it is proposed that a few drops of chloroform may be added when preparing solutions for subcutaneous injection which readily undergo putrefaction, and from

which the chloroform may be driven by heat or exposure to the air before the solution is used; and also to employ it internally in those diseases of the digestive organs dependent upon the presence of micro-organisms, particularly in the stomach. It is a useful and cheap preservative for anatomical preparations. As Salkowski has administered to dogs, weighing 36.8 kilos, no less than two hundred cubic centimeters, or nearly seven ounces of chloroform-water with the food for four days without the production of any symptoms, it would seem probable that its internal use in man is without any danger. It has been proposed that chloroform-water should be added to milk or other foods during artificial digestion, when the process is to be stopped in order to avoid the development of the bitter taste. As, however, chloroform does not act upon digestive ferments, this use of it would seem to be theoretically and practically impossible.—*Ibid.*

**COMMUNICATION OF TUBERCULOSIS.**—An instructive case of communicated tuberculosis is related by Dr. E. von Duhring, who states that a girl, aged fourteen, sprung from a family uncontaminated with phthisis, was in friendly relations with a young friend who died of consumption. At the time when this girl died, the patient, E. Z., was in good health. Shortly after the death of the friend she removed the earrings, which the other had worn, from the ears and fastened them in her own. The mother stated that the girl who had died had no wound in her ear, but E. Z. herself, on the contrary, states that her friend had frequently blood and matter on her ear. The patient, E. Z. herself, had up to that time never worn earrings, although the ears had been bored for that purpose. Shortly after she began to wear the earrings the holes through which they were fastened began to secrete freely, notwithstanding which she continued to wear them, and she had continued to wear them up to the time when Dr. Duhring saw her. It was on account of the condition of her ears that she was brought to him. He found her pale, somewhat thin, but well built and well developed for her age. Where the left ear had been pierced there was a shallow ulcer with undermined borders, and on the left side of the neck there was a slightly enlarged gland adherent to the skin, which was ulcerated on the surface and covered with a dirty scab. On removing the scab a somewhat abundant thin secretion escaped. The borders of this ulcer were irregularly dentated. On examining the

lungs, there was a dullness detected in the left apex. Granulations removed with a sharp spoon from the wound in the ear showed the presence of tubercle bacilli. The further progress of the case was rapid, and at the time Dr. Duhring wrote his paper the patient was rapidly sinking from phthisis. *British Medical Journal.*

**A CONTRIBUTION TO THE THERAPY OF BACILLARY PHTHISIS.**—In such a hopeless disease as phthisis in any form, no reasonable mode of treatment should be neglected when all the ordinary methods fail. Of late it has been the fashion to suggest new plans of treatment in this disease, but few have been even in a small degree successful, if, perhaps, we except creosote as more recently prescribed.

Dr. Louis Weigert, in a communication to the *Internationale Klinische Rundschau*, No. 51, gives his principle of treating bacillary phthisis, and, even if it is not new, it is worthy of consideration. Heretofore in treating tuberculous cases the trouble has been that the bacilli withstand the antiparasitic means much better than the animal cells, that is, the treatment kills the patient before it destroys the bacilli; but it has been shown that the tubercle bacilli are particularly sensitive to heat. They flourish at 37.5° C. [99° F.], still less at 38.5° C. [100.8° F.]; they die in a month if exposed to a temperature of 50° C. [122° F.], and heated to 100° C. [212° F.] they die at once. Now, if man can inhale air, even if not hot enough to kill these bacilli, at least to prevent their increase, much will be gained. From this point Dr. Weigert makes the following statements:

1. Former experimenters were correct in their statements as to the above given temperatures.

2. In the case of the tubercle bacilli it is possible to weaken their power of development and growth by repeated sterilizations.

3. Dry air heated to 150°–180° C. [302°–356° F.] can be inhaled by man several hours, and these inhalations only cause a quickening of the pulse in the first few minutes, an increase in frequency of the respiration with deepened inspiration and an increase of temperature of 0.5°–1° C. [0.9°–1.8° F.], while the expired air is only 45° C. [113° F.]. After an hour the temperature returns to the normal and the patient is not affected. Weigert has not yet been able to find out the temperature of the air within the alveoli during these inhalations, and it is not easy to see how even a German can do this.

He has already treated a large number, and although he can not say in what stage of the disease the virulence of the bacilli is weakened, still he has, according to his statement, abated most of the symptoms and put the patients in the way of a cure. His apparatus, which is described with illustrations, consists of a stand much like a music-stand, with rack above for holding a book, if the patient desires to read during the inhalations. To this stand is attached a Bunsen burner, over which is a cylinder in which the air is warmed and to which a pipe and mouth-piece are attached.

The following is suggested by the author:

1. At first the inhalations should last a half hour twice a day, but should be increased as soon as possible to two hours twice a day. This is different in different patients. They should never last long enough to tire the patient.

2. The patient should take at first deep and later forced inspirations.

3. The temperature should begin with 100° C. [212° F.], and can, with most patients, be increased in a few days to 250° C. [482° F.]. This may be exactly measured by the thermometer near the mouth-piece. As the air is slightly cooled in the pipe after passing the thermometer, it is not likely that the patient gets it at 250° C.

4. In case of hemorrhage the inhalations must cease.

5. In hemoptysis and pleuritic complications the inhalations may be kept up with shallow inspirations.

6. After inhaling, the patient should remain a half hour lying down, and then in favorable weather he should go out. Of course antipyretics and other treatment may be used at the same time if necessary.

Weigert's whole plan and the results are very rose-colored. Still any thing is worth trying in such a hopeless disease, and where all means fail it would be no difficult matter to make a simple inhaling apparatus after the pattern of the one described.—*Maryland Medical Journal*.

RECENT OBSERVATIONS RELATING TO INTUBATION.—Dr. Francis Huber, chief of the Clinic for Diseases of Children, College of Physicians and Surgeons, New York, read a paper on Recent Observations Relating to Intubation of the Larynx before the New York Academy of Medicine, October 24, 1888. This paper is supplementary to one read before the Academy, June 2, 1887, and is published in the Archives of Pediatrics, January, 1889. He states that of 94 cases

there have been 37 recoveries—about 40 per cent. Patients over three years of age numbered 45; of these 20 recovered—about 44 per cent; while of the 49 under three years of age, 17 recovered—about 35 per cent. Thus he very properly regards as a favorable showing, especially when it is borne in mind that the larger proportion of the cases occurred in thickly populated districts under the poor hygienic and sanitary conditions existing in tenements. The cases were not selected. Intubation was resorted to, no matter what complication existed, when the stenosis became sufficiently grave to warrant operative interference. He states also that they were late cases.

As regards the time for performing intubation, Dr. Huber says he does not favor early operation, because he has seen a comparatively large number of patients recover under the faithful employment of the bichloride of mercury and steam.

The difficulty in feeding, the strongest and most valid objection to the method, may be overcome in great measure by the employment of a trained nurse, personal supervision on the part of the physician (the idiosyncrasies of each patient as regards the ability to swallow liquids being carefully studied), the use of solid and semi-solid nourishment, rectal or forced feeding through the stomach-tube by the mouth or nares, and intermittent intubation.

If the symptoms in a case lead to the belief that the trouble is localized in the larynx and trachea, a full-sized tube should be inserted. A smaller tube may be inserted (with a view to being coughed out after a variable period of time) when membrane is suspected in the bronchi, or to relieve the recurring dyspnea occurring in some cases upon the removal of the larger tube at the fourth, fifth, or sixth day.

Intermittent intubation, he says, offers the following advantages: Food, medicines, and stimulants may be administered in the interval. If membrane exists or is loose below the tube, there is less danger of occlusion, for the tube is readily coughed out, and with it the membrane. The time of wearing the tube is materially shortened. The spasm which sometimes occurs when the larger tube is removed on the fourth to the sixth day is relieved by the insertion of a smaller tube, and when the latter is coughed out, usually in from six to twenty hours, the patient will be found to breathe without difficulty.

He asserts that his deductions are not theoretical or imaginary, but are based

upon numerous and careful observations, verified in a number of cases. He admits that intermittent intubation has been advocated before, but plan proposed differs from the one he uses, in that the tubes (full-sized) were removed at intervals and reinserted after the child had been fed. Dr. O'Dwyer, in detailing his second series of cases, incidentally refers to the advantages afforded by employing smaller tubes in certain cases. Dr. Huber's investigations in this respect were conducted without a knowledge of what had been accomplished by Dr. O'Dwyer.—*Medical and Surgical Reporter.*

**PHENACETIN.**—Pesce has communicated to the Royal Academy of Turin some clinical observations upon phenacetin. It effects pronounced and lasting fall of temperature, and has a favorable influence upon the general condition of the patient. This fall and the subsequent rise of temperature occur nearly always slowly and gradually. Seven and a half grains usually produce a fall of two or three degrees C.; this dose should be given once. The fall of temperature usually occasions no disagreeable or dangerous symptoms apart from perspiration, which is never copious.

Phenacetin also possesses a powerful anti-rheumatic action; it suppresses the fever and the pains in the joints, lessens the feeling of oppression, and makes the movements of the joints freer. It also exerts a favorable influence upon apyretic rheumatism, but upon the disease process itself it has no effect. It is of service as an analgesic in neuralgia, headache, migraine, and conditions of irritation of the sensory nerves. As a rule, seven and a half grains are sufficient to cause disappearance of the pain; where it is necessary this dose can be repeated after two or three hours. In disturbances arising from compression or from anatomical or functional lesions of the nerves, such as neuritis, fifteen and a half grains must be employed, and repeated if necessary.—*Deutsche Med. Wochenschrift.*

**THE SUPPRESSION OF DIPHTHERIA.**—At the meeting of the Chicago Medical Society, held January 21st, Dr. C. W. Earle read a paper on "The Contagious Character of Diphtheria." The writer agreed with the generally accepted view of its etiology, but claimed that the profession seemed to quite frequently fail to grasp the real necessity for notification, isolation and disinfection. In the discussion which followed, Dr. O. C. DeWolf spoke of the difficulty he experienced

in receiving notification of the cases to enable him to placard houses. He was quite sure that no means was more efficient in preventing the spread of diphtheria than the simple placard, and in his experience householders did not object to the notice, as it was for the general good; but he desired an expression from the Society as to the duty of every medical man to promptly notify the Health Department of the occurrence of diphtheria.

In closing the discussion Dr. Earle moved the adoption of resolutions declaring it the duty of the profession to so report, and the resolutions were adopted with only one or two dissenting votes.

When the great mortality from this northern scourge is considered, it is wonderful that no more active steps to limit its spread and propagation are taken. There were nearly a thousand deaths in Brooklyn, and eight hundred and fifty-eight in Chicago during the past year, and these great numbers are not materially in excess of the ratio in other cities of the northern section of the Union.

If there were ten per centum of this mortality from yellow fever, smallpox or cholera, public opinion, the potent factor in moving things in this country, would compel immediate concentration of sanitary forces upon this important question.

It is well known that isolation of these cases and disinfection will prevent its spread; why not apply the remedy?

The method of disinfection may well claim attention, for unless well done it is but a broken reed to lean upon. The disinfection in cases of diphtheria should include thorough application of antiseptic solutions to the throat and nasal passages of the invalid; disinfection, by bichloride of mercury, of all excreta, whether sputa or fecal matters, the boiling of all linen used or worn in the bed-chamber, the frequent sponging of the walls of the sick-chamber with the "blue solution" or the solution of bichloride of mercury, the spraying of the upholstery with the same, and, after disposal of the case, the thorough fumigation of the sick-chamber with the fumes of burning sulphur, and if there be a carpet, it should be sent to a steam cleaner.

These are the means which have been taken by that most efficient health officer, Dr. J. Y. Porter, U. S. A., at Jacksonville, Fla., for the prevention of the recurrence of yellow fever, and the same active and energetic treatment is needed elsewhere in dealing with the greater pestilence, diphtheria.

Let us hope that the efforts of health officers everywhere, in trying to limit the spread and arrest the propagation of diphtheria, may be supported and sustained by every means within the power of the profession. *Journal American Medical Association.*

**TYROTOXICON IN MILK.**—On Friday evening, November 9th, Dr. George E. Francis brought me a pint of milk, and gave me the following facts:

"I was called this morning to attend five persons in one family suffering from an attack of cholera morbus. On inquiring, I found that, of the two members of the family not ill, one had taken no cream or milk, while the other had taken only boiled milk with her breakfast. The five members who were ill had all taken cream or milk of the previous day, and the symptoms of poisoning had begun about two and one-half hours after breakfast."

The milk was in a pint beer bottle with patent rubber stopper, and appeared and tasted perfectly fresh and good. After carrying it to the laboratory it was allowed to remain in the tightly stoppered bottle for one week before it was examined. The milk had by that time decomposed, separating into two layers. It was filtered through thick Swedish filter-paper, the filtrate neutralized with a dilute solution of sodium hydrate, placed in a separating funnel, and shaken thoroughly with ether. A thick emulsion formed, and it was only after four days, and by the use of various mechanical means, that a separation could be effected. The ether solution was allowed to evaporate at the ordinary temperature, and the residue carefully tested. Reactions were obtained which agreed perfectly with those given by Vaughan, *Journal of Analytical Chemistry*, vol. 1, pp. 25, and 281, for tyrotoxin.

There is therefore no doubt that the poisonous action of the milk was caused by the same poison that Vaughan found in the various cases cited by him.

A visit to the dairy from which the milk was obtained was made, and it was found that the herd consisted of fifteen Jersey cows, all in the best condition, well fed and cared for. The dairy supplies about forty families with milk, and the milk of all the cows is mixed together before subdividing it into the various portions. And as only one family out of the forty supplied with the milk, as far as can be found out, suffered from any poisonous effect, it proves that the poison was developed after the milk had been delivered. This was also found to be the fact on questioning the serv-

ants of the family poisoned. The milk had been received in a tin can, which it was their business to keep clean, and it had been immediately subdivided into two portions. One portion was placed in an earthen dish to raise cream, and the other was used during the same morning as fresh milk, without causing the slightest trouble. The symptoms of poisoning were caused by the first portion, after standing over night. The above facts seem to show that the tyrotoxin was developed during the twenty-four hours after the milk was received.

The only explanation of its development that I can at present give is that the cans used for obtaining the milk had not been thoroughly scoured with boiling water, and that a little old milk remaining on the inside edges of the can had undergone a peculiar fermentation, and had caused the development of a sufficient amount of tyrotoxin, during the twenty-four hours it had remained in a cool place, to produce the poisonous action.

I have been led to describe thus fully the above case, as up to this time almost nothing is known as to the cause of the formation of tyrotoxin in milk. I have, I think, pointed out in one way in which it may be developed, namely, the use of cans which have not been kept perfectly clean, but it is only by the careful examination of a number of cases that it will be possible to decide whether the formation of the poison is due solely to such causes.—*L. P. Kennicut, D. Sc., Boston Medical and Surgical Journal.*

**PROFESSOR LEBER ON INFLAMMATION.**—Professor Th. Leber, of Göttingen, has lately been engaged in some investigations having for their aim the solution of the question whether suppurative inflammation is exclusively produced by micro-organisms, or whether it may also be set up by purely chemical substances. By means of injections of completely sterilized cultures of staphylococcus pyogenes aureus into the anterior chamber of the eyes of rabbits, he was able to induce intense suppurative inflammation. This, however, differed from similar inflammation produced by living staphylococci, inasmuch as it showed no disposition to spread; and even when the local appearances were of a very severe nature the morbid process rapidly came to an end. From staphylococcus cultures different chemical crystallized substances were obtained, which were shown by their reactions not to be identical with the ptomaine obtained by Brieger from staphylococcus cultures, and which he, in consequence of its

property of setting up suppurative keratitis, denominated "phlogosin." Besides, Professor Leber was able by means of his investigations to show that when suppuration was set up the pus corpuscles made their way in a centripetal manner toward the spot where the inflammatory stimulus exists. He found that capillary tubes containing a small quantity of a substance capable of inducing inflammation when introduced into the anterior chamber of the eye became filled after a time with pus, while no pus at all could be detected in the eye itself. Professor Leber considers this attraction of leucocytes by chemical substances as analogous to the attractive influence of certain chemical substances in vegetable cells which has already been observed, and which has received the name of "chemo-tactical action." Finally, Professor Leber finds that in suppurative inflammation fibrin and the tissues become dissolved by means of leucocytes; for example, pieces of cornea impregnated with sterilized staphylococcus culture, when introduced into the anterior chamber of the eye, became rapidly dissolved. It was found, moreover, that pus, when free from bacteria, enjoys the property of causing a local liquefaction of nutritive gelatine. Professor Leber recognizes in these properties of leucocytes (their ability to absorb foreign bodies and to dissolve fibrin and tissues) a valuable defensive arrangement which tends to shield the organism against external injuries. He would therefore look upon inflammation as an "important process, which consists in rendering the organism obnoxious to external injurious influences." *London Lancet*.

**TOPHACEOUS DEPOSITS ON THE SKIN IN GOUT.**—At a recent meeting of the Edinburgh Medico-Chirurgical Society, Professor Grainger Stewart showed a case of gout with numerous tophaceous deposits in the skin. The patient was a man, aged fifty-eight, who had suffered from gout for twenty-three years, the hands having gradually become so deformed as to make work impossible for a long time past. Till lately there was no manifestation except in the joints and skin, but albuminuria had now appeared, and hyaline casts were sometimes seen. Probably there was no case on record with so many deposits in the skin. The case was well known in the London hospitals, and has been referred to by Dr. Pye Smith in the last edition of Hilton Fagge's book. The family history could be traced back at least a hundred years on both father and mother's

side, and there was absolutely no case of gout on either. Though he was not an abstainer he was not a self-indulgent man, and his personal habits did not give them any clue to the cause of the early and severe development of the disease.—*Edinburgh Medical Journal*.

**AN ERUPTION FROM THE USE OF SULPHONAL.** The employment of sulphonal as a hypnotic has been followed by an eruption in one case occurring in the practice of Dr. Engelmann. (*Wiener Medizinische Blätter*, November 1, 1888.) The patient was a woman, forty years of age, suffering from chronic metritis, with violent dysmenorrhoeic pains, in which sulphonal was given to relieve the insomnia, after chloral had failed. Thirty grains of sulphonal were given at bed-time; no hypnotic effect was noted, but on the following morning a diffuse scarlet-red eruption appeared, accompanied by itching under both breasts. The red coloration of the skin was sharply separated from the normal skin and rapidly extended, so that on the evening of the same day it had covered the internal sides of both arms in a perfectly symmetrical manner, and reached to the sternum; on the morning of the following day it had extended to the abdomen, and the eruption, which had been distinct on the two sides of the body, was now confluent. On the third day the eruption, which was now the seat of violent itching, gradually disappeared. It has been noted by Lesser that in the majority of cases the production of eruptions from the use of drugs is to be explained as attributable to vaso-motor disturbances, a theory which in this case appears to be sustained by the perfectly symmetrical character of the eruption.—*Therapeutic Gazette*.

**SULPHONAL.**—Dr. J. Mason Windermere says, "I have found it very useful in an obstinate case of insomnia. The patient is a gentleman over seventy, who has frequently for months at a time suffered from sleeplessness. He has used every drug of repute, both new and old, but none except sulphonal have given him natural sleep, and all with after-effects so unpleasant as to necessitate their discontinuance. He has taken sulphonal in twenty-grain doses twice a week or so for many weeks; it has never failed to procure three or four hours sleep, and he observes that he is rather drowsy next day, and sleeps soundly the following night, and generally the night after as well."—*Edinburgh Medical Journal*.

# The American Practitioner and News

"NEC TENUI PENNÂ."

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D. W. YANDELL, M. D., )  
H. A. COTTELL, M. D., ) Editors.

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## DR. OLIVER WENDELL HOLMES' LIBRARY.

On the 23d of January Dr. Holmes gave his large medical library to the Boston Medical Library Association. The event was duly celebrated on the 29th by a reception given in honor of the gifted donor, who honored the occasion with a characteristic address. The speaker took his library for a text, and showed in his remarks a familiarity with medical literature not surpassed by the veriest book-worm in a specialty. This is remarkable, when it is remembered that Dr. Holmes has attained the highest rank in general literature as poet, essayist, biographer, critic, and novelist. A few excerpts from the address (Boston Medical and Surgical Journal) will bring to the reader's view once more the friend of old days, whose genial thoughts at four-score are like fresh young leaves upon the oak of a century:

"This collection has grown by a slow process of accretion during nearly three-score years. The first of these books which I remember owning is Bell's 'Anatomy;' the last accession is the beautiful little volume which I bring with me this evening, 'Elements of Pharmacy, Materia Medica, and Therapeutics, by William Whitla, M. D., physician to the Belfast Royal

Hospital, fourth edition." I have not counted the number of volumes, but the librarian informs me that there are something over nine hundred. The list of titles reaches twelve hundred and thirty-one, but the same book is in many instances given under different headings. The oldest book in the collection is a black-letter copy of Avicenna, dated in 1490, the most recent, 1887—so that they cover very nearly the space of four centuries. Most of these volumes I have bought, but a considerable number have been presented to me by their authors or by friends. I trust that those of my friends who may chance to see one or more of the books they have presented me on these shelves will not think I have forgotten their kindness in allowing their gifts to follow the fortunes of the little mob of volumes in whose company they found themselves."

"Let me remind you, that if you wish to understand the pseudo-scientific vagaries of today you will find more instruction in the 'Ortus Medicinæ' of Van Helmont than in any other old work with which I am acquainted. The infinitesimal, or make-believe, dosing is to be found in the chapter entitled 'Butler.' Butler was an Irishman in a Belgian jail, where Van Helmont found him. He had a pebble which he used to dip in oil, then take a teaspoonful of that oil and add it to a small flask of the same oil and apply one drop of this to the ailing part. Then he would give his pebble a lick with his tongue, and clap it in his waistcoat pocket. This whole chapter, 'Butler,' should be read by the student of Hahnemann and by all intelligent students of medical history. The doctrine of the 'mind cure' is abundantly illustrated in other chapters of the 'Ortus Medicinæ,' the date of which in my copy, now yours, is 1652.

"Do not look with contempt, then, on such of your old books as seem to be mere treasures of unwisdom. The *débris* of broken systems and exploded dogmas form a great mound—a *Monte Testaccio* of the shards and remnants of old vessels which once held human beliefs. If you take the trouble to climb to the top of it you will widen your horizon; and in these days of specialized knowledge your horizon is not likely to be any too wide."

"Since medicine has run into specialties, as it did thousands of years ago in Egypt, there must be forming great numbers of private libraries, more or less complete on their particular subjects. We may hope that in time all the important branches of medical science and practice will be fully represented on our shelves. But the enormous amount of material already accumulated in many special departments would be of comparatively little use without indexes to point out the way to find what is wanted. The great "Index Medicus," prepared at Washington under the direction of the admirable Dr. Billings, is the master-key to the storehouses of knowledge which, without it, few would ever have even tried to open.

"These books were very dear to me as they stood upon my shelves. A twig from some one of my nerves (as I remember saying long ago) ran to every one of them. From the time when I first opened Bell's "Anatomy" to that in which I closed my Sharpey and Quain and my Braithwaite's "Retrospect," they marked the progress of my studies, and stood before me as the stepping-stones of my professional life. I am pleased that they can be kept together, at least for the present; and if any of them can be to others what many of them have been to me, I am glad to part with them, even though it cost me a little heartache to take leave of such old and beloved companions."

#### JOURNAL AMERICAN MEDICAL ASSOCIATION.

With the issue of February 9th, Dr. John B. Hamilton severed his editorial connection with this journal. His reason being that the Marine Hospital Service Bill, which for the ten years past has been pending, passed both houses of Congress in January last and became a law. The effect of this is to create a life-tenure in the office of Supervising Surgeon General.

The retirement of Dr. Hamilton from active editorial work is a loss to the cause of sound journalism, and a disappointment to the Association. His many friends will rejoice to see him fixed for life in a seat which he has magnified and adorned with rare ability and grace.

#### SURGICAL SECTION, A. M. A.

The secretary requests that the titles of all papers prepared, or in preparation for this section, be sent to him at the earliest possible day. If the titles are to be inserted in the Association programme, they should be in his hands at least eight weeks before the day of meeting.

Address W. O. Roberts, M. D., 706 West Chestnut Street, Louisville, Ky.

#### Notes and Queries.

##### MIND-READING.

*Editors American Practitioner and News:*

During the exhibition of mind-reading by Washington Irving Bishop, just closed at Masonic Temple, I had the opportunity that I have long wished for, of making a satisfactory investigation of his claims, and of the feasibility of mind-reading. In the article, *Philosophy of Memory*, kindly published by you in the *News*, I admitted my belief in the possibility of this performance, and loosely outlined the mode in which I thought it might be performed.

A close study of the performances of Mr. Bishop, and careful personal inquiry, confirms me fully in the views expressed in the article referred to, leaving me as they have in the most thorough confidence in the fairness and genuineness of the manifestations. A few only of these manifestations can be here described, and that briefly.

The first step was to have the audience elect a committee of well-known men as subjects for the experiments.

One of these experiments was to have a member of the committee to take a knife, to go out into the audience and pretend to stab some person and then hide the knife, Mr. Bishop himself being all the while in care of a part of the committee completely out of sight in the dressing-room. Then, coming out, blindfolding himself, and taking the hand of the person who had gone through the pantomime, he would lead him to the

knife, find it, and go through the motion of giving the fatal blow, just as the other had done.

Again, taking any of the committee, he would ask him to think of some dead acquaintance and of the character of his handwriting, together with four or five living acquaintances, the names to be written on a piece of paper and placed in a sealed envelope. This was done by Dr. White, Dr. Satterwhite, and others, and without once failing Bishop gave the name of the dead person, his description, and his handwriting. Repeatedly persons were made to write the name of some one in the audience on a piece of paper, put this into an envelope, seal it, and then think intently on the appearance and dress of the person so named. This envelope with the contained name Mr. Bishop never failed to deliver to the right man.

A number of gentlemen of the committee were sent out to hide a needle, while he remained in the Temple entertaining the audience. These gentlemen left the hall, and of course could not be seen to pass out of the door into the street. They took the needle to a dry goods store around the block, and at first hid it in a glass box under a fold of paper. Then, thinking they might better hide it in a case of drawers containing several thousand needles, they took out a drawer and put the needle in a paper of needles, and replaced the drawer. Mr. Bishop took three of the committee who hid the needle, and, leading them by a strand of copper wire about six feet long, went directly to the case where the needle had first been hid, and lifted up the paper under which it had rested. After making the committee own that it had been there, he proceeded to the drawer and picked up the paper in which the needle had been finally placed.

On another occasion Dr. White took position across the room, at a distance of some thirty or forty feet, holding in his hand a copper wire, the other end of which was tied around Mr. Bishop's head. Dr. White was told to think of any tune with which he was familiar. At once Mr. Bishop struck

up "Dixie" on a piano at which he was seated, and Dr. White declared it was the tune he had in mind.

These are only a few of the many feats of the kind performed by Mr. Bishop, he freely declaring that he performed them altogether through natural agencies, in a way that he himself did not claim fully to understand.

I now propose to offer an explanation of these manifestations based in the principles laid down in the *Philosophy of Memory*.

Science has now settled down to the conclusion that all force is a mode of motion. As action and reaction are equal, it follows that all motion must ultimately consist of waves or undulations. All molecular force actually, as far as is known, consists of such waves. This fact is particularly established in the case of light, heat, and electricity, and nearly as well in regard to nerve force.

But without discussing this point farther, let us assume that all our operations are carried on by means of these infinitely little waves: that our thoughts and ideas are constituted by them as truly as bricks constitute a house—and of this there can hardly be a doubt. Now let us suppose further that these waves are also capable of extending to a certain distance outside of our brains, either through the air or other conducting media, and it is not more strange that Mr. Bishop reads the minds of those with whom he is brought into favorable contact, and carries out the ideas that are in their minds, than is their doing so themselves.

Take as a most complex example the finding of a needle on Thursday evening, hidden by the committee in the needle drawer at Lewis'. Say Prof. Huntoon, one of the committee, after having hidden it, should have started from the stage to find it, and also suppose that he should have blindfolded himself. The undulations that in his brain constituted the record or memory of all the steps to be taken would have reacted on his muscles and compelled them to make just such movements as would have carried him to the place where the needle was hid, moved his hand to it and picked it up. Any one of the committee might have gone there and

got it blindfolded. Many a blind man, having hid it, without any hesitancy would have done so. Now, if we admit that all the undulations acting in this direction in the brains of any one of the committee could have been extended to the brain of Mr. Bishop and there been set to work, his going and picking up the needle would have been as simple as the act on the part of any one of the committee.

The concentration of mind required by the performer might aid in two ways. The congestion resulting to the active parts of the brain might increase their activity and the force of the undulations, or, by withdrawing blood from other parts of the brain and disbanding the groups of undulations making up other thoughts; might prevent them from confusing.

It is not to be supposed, of course, that the intensity of undulations is increased in this way, for this would change their character and be fatal to their office; more likely the effect of congestion is to increase conduction facilities among the cells, and enable many of them to concentrate their action, just as sleep conversely may be the isolation of the cells so as to prevent their acting in concert.

Nor is it to be supposed that these thought-waves reach Mr. Bishop any more than others at the same distance; the delicacy of his nervous organization enables him to perceive and respond to what others can not. It is plain, that to do the best work, if not to do any, he should be blind-folded; for while impressions obtained through our eyes aid in guiding us to the place, but not in choosing the direction—for that must have been done from memory—his eyes could bring only disturbing undulations to his brain.

Not only must the brain-waves exist in our minds, but they must be orderly. Just as by the sound of a voice we may be made to go this way or that, so by the unheard brain-waves the muscles must be made to move this way or that. In the musical experiment, in which Mr. Bishop plays a tune which a person connected with him by a wire across the entire hall is thinking of,

waves must travel to his brain in such order as they would travel from the brain of the individual, who thinks of the tune, to his hands, if he himself were playing it.

Every act performed by Mr. Bishop can be explained on this hypothesis.

Mark also how well all this bears out the doctrine that memory consists of waves which are merely persisting thought or impression waves. In the example of the tune, every different note must have been kept alive in the brain of the subject (Dr. White) by a different character of wave. Not only so, but these must have traveled or extended along the wire, together with the waves that act on the muscles, to enable them to reproduce these notes. This goes to show, also, that the force which keeps up memory is in some respects different from common nerve force, for nerve force can not be conducted through wire.

If we may believe the testimony of witnesses, there have been still more wonderful performances than those of Mr. Bishop, notably those of Mollie Fancher, who died recently in New York. In the presence of Rev. Dr. Prime, Dr. Duryea, and a number of others as fully entitled to belief as ever men have been, she was able to read and recompose printed lines on paper that had been cut into bits and put into an envelope. It was said to be a common thing for her to read letters the contents of which no one present knew. In the case referred to, the gentlemen named took a piece of the Congressional Record, and, cutting it into bits, put them into an envelope, and this into others until they were enveloped three thick. She took her pen, with her hands back of her head, a position she could not remove them from, and wrote out the lines correctly and consecutively. But now and then, where there was a break in the sense, she made a dash and left a space blank. On taking out the bits of paper and placing them together it was found by the committee that they had left out the bits corresponding to these dashes, and on going home they were found lying on the floor where the cutting had been done.

In this case it must be assumed that the undulations from the printed letters within the envelope passed through the envelopes and affected her sensitive brain cells in the same way that, if exposed, they might have affected the eyes of other people. She saw them in this way without eyes. They were all before her mind's eye to choose from. And just as an ordinary person might, with his eyes, put the bits of a letter together, leaving blank the spaces where the sense showed that some part was wanting, so she could reconstruct the bits submitted to her.

That the atoms of all matter are in a state of constant vibration, and that every kind of matter has a different character of vibration, is the accepted doctrine of science, only in this case we must suppose that the brain of this girl was sensitive enough not only to perceive undulations sensible to the smallest number of people, but also to completely distinguish their order. All these examples are wonderful indeed, but not a whit more wonderful than our every-day mental operations. They excite our wonder only because they are exceptional.

LOUISVILLE.

D. T. SMITH, M. D.

**DEATH BY ELECTRICITY.**—Growing out of the controversy between electrical engineers regarding the comparative lethal effects of the alternating and continuous currents of high intensity, as proposed for the execution of criminals in New York, the following singular challenge has been sent for what may be called an electrical duel:

"In conclusion I desire to offer Mr. Westinghouse the following challenge: He asserts that the alternating current is less dangerous than the continuous current, but he has not proved it. I have asserted that the alternating current is five times as dangerous as the continuous, and I have proved it to be so in many cases. I therefore challenge Mr. Westinghouse to meet me in the presence of a committee of electrical experts, and take through his body, from hand to hand, the alternating current, with the same number of alternations per second as used by the Westinghouse company, while I take through

mine a continuous current. We will then commence with fifty volts, Mr. Westinghouse, of course, leading, and will gradually increase the pressure until either one or the other has cried 'enough,' and admitted his error, each contact to be for a period of five seconds. I warn him, however, that the alternating current at one hundred and sixty volts for five seconds has proved fatal in my experiments, and that several men have been killed by the low-tension Jablochhoff alternating currents.—*Harold P. Brown, Boston Medical and Surgical Journal.*

**PHILADELPHIA CLINICAL SOCIETY.**—At the annual meeting of the Philadelphia Clinical Society, held January 25, 1889, the election of officers for the following year resulted as follows: *President*—Dr. Marie B. Werner. *First Vice-President*—Dr. Amy S. Barton. *Second Vice-President*—Dr. Rebecca Fleisher. *Treasurer*—Dr. L. Brewer Hall. *Corresponding Secretary*—Dr. Emily Waterman Wyeth. *Recording Secretary*—Dr. Mary Willits. *Reporting Secretary*—Dr. Mary Willits. *Councillors*—Dr. Anna McAllister, Dr. Cornelia Kahn, Dr. Mary E. Allen, Dr. James B. Walter, and Dr. I. G. Heilman.

**MESSRS. J. B. LIPPINCOTT COMPANY** announce to the profession the publication of a *Cyclopedia of the Diseases of Children, Medical and Surgical*, by American, British, and Canadian authors, edited by John M. Keating, M. D., in four imperial octavo volumes; to be sold by subscription only. The first volume will be issued early in April, and the subsequent volumes at short intervals.

A thorough knowledge of the diseases of children is a matter of the greatest importance to most physicians, and as this is the only work of the kind that has been published in English, it will be invaluable as a text-book and work of reference for the busy practitioner.

**METHOD OF ADMINISTERING GLYCERINE ENEMATA.**—The occasional complete failure of glycerine enemata in emptying the lower bowel led me, some months ago, to devise a

method by which the glycerine could be deposited higher in the rectum than by the ordinary way, on a plane with or above the fecal mass. I use a small, soft catheter, about 18 Fr., attached to a one-half-ounce hard-rubber syringe. The catheter can be gently inserted five or more inches in the rectum without giving pain. Since using this fewer failures have been noted, and as a rule the movement immediately follows the injection.

Filling a small syringe with glycerine is tedious, and time is saved by unscrewing the cap, removing the piston, and pouring in the desired amount of glycerine, allowing for the small quantity that must of course remain in the catheter. Where, as in a hospital ward, several injections are to be given, a larger syringe may be used, and a part given to each patient without refilling.—*Walter Chrystie, M. D., University Medical Magazine.*

**INSECT INSTINCT AND ADULTERATION.**—Bees are said by the *Lancet* to be unerring connoisseurs of saccharine substances. To the human palate cane sugar, beet-root sugar, and saccharin are pretty much alike, but bees will have nothing to do with the last two. They are partial to glycerine, but discriminate against impure samples. What is wanted in the country is an insect that will instruct inmates of hotels and boarding-houses in the mysteries of the butter-dish.

**ELECTRICITY FOR EXECUTIONS.**—The correspondent of the *Philadelphia Ledger* writes from New York, under date of January 6th, that it is not unlikely that, at the present session of the legislature, the law which went into effect the first day of the year, providing for the execution of murderers by electricity, will be repealed, or the time extended for its going into effect. It is not altogether sure, he says, that executions by electricity can be made without pain or mutilation. Electricians are divided on the subject, and the majority seem to be opposed to the law. It is noticeable that every electrical journal opposes the electri-

cal method of execution as inexpedient and inhuman, and in a recent address Professor Brackett, of Princeton College, spoke of execution by electricity as an outrageous thing, and the degrading of a noble agent to an ignoble use.—*Med. and Surgical Reporter.*

**CONVALESCENCE OF SIR WILLIAM GULL AND SIR WILLIAM JENNER.**—The *Lancet* states, under date of the 12th ult., that Sir William Jenner and Sir William Gull are improving in health. The former expected to be able to leave London at the end of the month for a few weeks' rest, and the latter was just able to leave his room.

**YELLOW FEVER BACILLI.**—Dr. James E. Reeves, of Chattanooga, has been studying the tissue of the liver and kidneys from patients who died with yellow fever at Decatur, Ala., and has discovered a micro-organism that closely resembles a specific germ. Dr. Reeves has sent mountings of these tissues to various bacteriologists in this country, and has had the bacilli photographed by Professor Delmoro, of the Ohio State University. Consultation of scientists will be held at Johns Hopkins University the first week in January, at which the micro-organism will be examined and discussed.

**LUMINOUS BACTERIA.**—According to the *Naturforscher*, Professor Pflüger and Dr. Tilanus have succeeded in cultivating, by Koch's method, the bacteria which produce the luminosity of sea fish. They have also been able to place them on a glass slide, which, in the dark, appeared thickly strewn with luminous points. Professor Van Haren Noman has succeeded in photographing them.

**DR. VON PETTENKOFER KNIGHTED.**—Dr. Max von Pettenkofer, Professor of Hygiene and State Medicine in the University of Munich, has been made Knight of the Order of the Crown of Italy, a similar honor to that conferred upon George M. Pullman of palaccar fame.—*Journal American Med. Association.*

# THE AMERICAN PRACTITIONER AND NEWS

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*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the fewest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want down-right facts at present more than any thing else. — RUSKIN.*

## Original Articles.

### DISEASES OF THE EYE, EAR, THROAT, AND NOSE.

Points of Interest to the General Practitioner.  
Deduced from 5,409 Cases of Diseases of  
the Eye, Ear, Throat, and Nose, seen  
in Private Practice, 1887-'88.

BY W. CHEATHAM, M. D.

*Lecturer on Diseases of the Eye, Ear, Throat, and Nose, University of Louisville, Kentucky.*

In this report I shall speak only of work done in my office (not of outside, hospital, or college work) for the years 1887 and 1888, and endeavor to draw from it such conclusions as may be of importance to the family practitioner.

From January, 1887, to January, 1889, I have seen in my office 5,409 cases, divided as follows: Diseases of the eye, 3,600; diseases of the ear, 681; diseases of the nose, 606; diseases of the throat, 522. Diseases of the eye were divided as follows:

Conjunctiva .....	752
Cornea .....	496
Iris .....	100
Lens .....	154
Ciliary body .....	9
Sclera .....	10
Optic nerve and retina.....	108
Muscles .....	180
Lids .....	274
Choroid .....	85
Vitreous.....	55
Globe .....	43
Orbit .....	13
Errors of refraction.....	1,239
Presbyopia.....	75
Miscellaneous .....	7
Total.....	3,600

I shall, for convenience, consider first the ear cases, and hope I may not make a useless appeal to the family practitioner when I beg of him to let the aurist see at an early day his acute cases of inflammation of the middle ear. It is still the practice of the laity to call the family doctor first to see such cases. Of acute catarrh of the middle ear, and acute suppuration of the middle ear, I saw, during the two years, but forty-four cases; of chronic catarrh and chronic suppuration of the middle ear I saw, in the same length of time, three hundred and sixty-nine cases. I believe the experience of aurists will justify the assertion that if we could see cases of acute inflammation of the middle ear in time, chronic cases would be rare indeed as compared with their present number. Many cases of acute catarrh of the middle ear appear to get well under the simplest treatment; the pain disappears, and the hearing is apparently restored; but the true after-result is that each attack leaves the patient a little more deaf; leaves changes in the throat, nose (disease of which is the most common cause), eustachian tube, and middle ear, which render them many more times liable to a series of attacks, to be followed by a chronic inflammation of the parts, with tinnitus, vertigo, and hopeless deafness; or probably a chronic suppuration of the middle ear, with polyp, disease of the mastoid cells, septicemia, pyemia, facial paralysis, abscess of the brain, and death. A recent writer says fifty per cent of the cases of abscess of the brain depend upon suppuration of the middle ear. I believe the gentlemen present will agree with me when I state that it is exceedingly rare to have any acute inflammations of the ear become chronic when seen early and properly managed.

Of my ear cases there are on my record-book but six in which the mastoid was involved. This small number is accounted for by the fact that they are usually seen as house patients, or, rather, at their homes, and I have consequently kept no record of them; of these six, four were disease of the bone, that is, necrosis. They all got well. I have, fortunately, never had a death from this cause. I have had to open the bone several times, and had Dr. W. O. Roberts do it for me once in a very severe case. These patients also made good recoveries.

Of the diseases of the throat, sixty-eight were acute inflammation of the tonsil, some follicular, some suppurative, etc. I believe most of these to have been rheumatic in origin, many of them being secondary to improper feeding, such as excess of sweets, etc. I found hot applications, both internal and external, with the salicylates and turpentine, gave the best results in their management. I find the old "Brown gargle," with salicylate of soda added, and with eucalyptol-water substituted for the distilled water, the best for people to keep on hand when subject to frequent attacks of acute follicular tonsillitis—this is also good for those subject to attacks of quinsy—but, in addition, I have them carry with them pellets of atropia sulphate and mercury protiodide, to be taken immediately on the first symptom; and by these, with proper feeding and hygiene, prevent and abort numerous attacks of this painful affection.

Of hypertrophy of the pharyngeal tonsil and adenoid vegetations in the pharynx, I saw twenty-nine cases. These are the most frequent causes of mouth breathing, with all its bad effects. Surgery alone comes to my relief in these cases, but it must be followed by active constitutional and hygienic treatment.

Of diphtheria I have seen many cases in the last two years, but only four cases in the office. In this disease I think the best local application, both theoretically and practically (when it can be gotten there), to be hydrarg. bichlo., say from one grain down, to muriate tinct. iron, one ounce: one grain to one ounce makes it 1-500.

Of cases of asthma depending upon disease of the mucous membrane and submucous tissue of the posterior part of the nose I found a good many, and found treatment directed to that part of the economy relieved many cases of long standing. These cases can be differentiated by the local use of cocaine posteriorly.

Of "hay-fever," the name by which a peculiar periodic affection is most commonly known, I saw twenty-eight cases, a majority of them getting relief under treatment. I found a majority of them needed treatment each year, and that the most favorable time for treatment is just before or at the first part of the attack. As a local application, to be used at home, I give cocaine (alkaloid), and menthol, and, to prevent the drying effect of the cocaine on the mucous membrane, I add oil gaultheria and oil of eucalyptol, and sometimes, for its control over venous congestion, hamamelis, to the vaseline or vaseline oil. For engorgement of the nasal tissue, cases of which are quite numerous, I use the galvano-cautery, endeavoring, when possible, to reach the submucous tissue, where the difficulty is located, through as small an opening as possible, so as to leave a small cicatrix. For the same reason, in these cases, where ridges of bone spring from the septum and extend out far enough to produce stenosis of the nose, I have had made burs with long shanks, to be attached to the dental engine, and with these go under the mucous membrane, drill out the bone to a thin shell, then crush it in, thus preserving the periosteum, and leaving, as I stated above, an exceedingly small cicatrix. I have neither seen nor heard of any one else practicing this method. It is much less painful than the Bosworth saws or any other procedure I have seen practiced, and is much more effectual.

In the three thousand six hundred eye cases there has been much observed which is of great interest to the family doctor. In diseases of the lid and conjunctiva we have a prolific cause of headache; simple hyperemia of the conjunctiva is a most com-

mon cause: it too, on the contrary, is the result of disease of many of the distant organs, for instance, the stomach, liver, and uterus. In diseases of the cornea and iris we have an index to many of the most common and most obstinate general diseases. By these we can frequently judge of the effect of our treatment in either acquired or congenital syphilis. I have recorded, in the last two years, twenty-six cases of inherited syphilis showing in the cornea first. I have on record twenty-seven cases in which the external and internal muscles of the eye were involved, being the first symptom noticed in beginning locomotor ataxia. I had at one time fourteen cases of this affection under observation. Besides these, I had several cases in which atrophy of the optic nerve was the first symptom to attract attention; one case in which the first symptom was a periodic paresis of the abductors of the vocal chords; eighty-one cases of convergent squint, and eleven cases of divergent squint. Muscular insufficiencies I found to be an extremely common cause of headache and vertigo. There were seven hundred and fifty-two cases of disease of the conjunctiva. Over one third of the occupants of our institutions for the blind lose their vision from a disease of the conjunctiva, "ophthalmia neonatorum," the management of which is exceedingly simple. I have yet to lose an eye from this disease when I see it before the cornea is involved. Cleanliness by means of carbolized hot water and surgical cotton, glycerole of tannin to clean out the *cul-de sacs*, and nitrate of silver, followed by salt water, and a weak solution of atropia sulph., is my routine treatment. It all amounts to nothing without cleanliness. The nitrate of silver is both antiseptic and protective; it protects by coagulating albumen. I had one hundred and fifty-four cases in which the crystalline lens was involved. Opacity of this body is frequently the first indication we have of diabetes.

The iris alone was involved in one hundred cases. This little membrane or diaphragm, perforated in or near its center by

the pupil, is consulted more often than any other part of the eye by the general practitioner. One chapter "On the Pupil in Health and Disease" in a small book on "Diseases of the Eye," by Swanzy, is worth many times the price of the book. Pages and pages can be profitably written and read concerning this small membrane alone. Swanzy says as follows:

"Chloroform in the first or exciting stage of anesthesia, according to the investigations of Westphal, Budin, and Hirschberg, stimulates the pupil-dilating center, and in the second stage gradually reduces the excitability of this center, until finally it is completely paralyzed, so that no form of stimulation causes any dilatation. Following on this is a still further contraction to a pin-hole pupil, due to stimulation of the pupil-contracting center. Should the inhalation of the anesthetic be longer continued, a dilatation of the pupil often suddenly takes place, and this indicates paralysis of the pupil-contracting center, and the most serious consequences for the life of the patient."

"The size of the pupil in disease (myosis) may be caused by a diseased process irritating the pupil-contracting center or fibers (the irritation myosis of Lesser), or by one causing paralysis of the pupil-dilating center of fibers (the paralytic myosis of Lesser), or by a combination of both. Either cause alone would produce a medium myosis; a combination of the two would give a maximum myosis."

"Irritation myosis, according to Lesser, is not usually increased by the stimulus of light, nor on convergence of the visual axes, nor does it diminish in the shade. Mydriatics dilate such a pupil widely, myotics contract it to maximum. In paralytic myosis the pupil reacts well to light and on convergence, but does not dilate on application of sensitive or psychical stimuli, or with co-ordinated motions. Mydriatics dilate such a pupil only partially, while myotics contract it to maximum. In maximum myosis every reaction is wanting, strong mydriatics alone producing a medium dilatation.

"Irritation is found in: (a) The early stages, at least, of all inflammatory affections of the brain and its meninges, in simple tubercular and cerebro-spinal meningitis. When in these diseases the medium myosis gives place to mydriasis, the change is a serious prognostic sign, indicating the stage of depression with paralysis of the third nerve. (b) In cerebral apoplexy the pupil is at first contracted, according to Berthold, who points out that this contraction is a diagnostic sign between apoplexy and embolism, in which latter the pupil is unaltered. (c) In the early stages of intra-cranial tumors situated at the origin of the third nerve or in its course. (d) At the beginning of an hysterical or of an epileptic attack. (e) In tobacco amblyopia, probably from stimulation of the pupil-contracting center by the nicotine. (f) In persons following certain trades, as the result of long-maintained effort of accommodation (watchmakers, jewelers, etc.), the pupil-contracting center being subject to an almost constant stimulus. (g) As a reflex action in ciliary neurosis; consequently in many diseased conditions of those parts of the eye supplied by the fifth nerve."

"Paralytic myosis occurs in spinal lesions above the dorsal vertebræ, for example, injuries and inflammations, especially of the chronic form. The contracted pupil occurring in gray degeneration of the posterior columns of the spinal cord has long been known as spinal myosis. In the simple form of this myosis the pupil has but a medium contraction, and reacts both to light and on convergence. This condition is found in the early stages alone, when the disease has attacked only the cilio-spinal center, or higher up as far as the medulla oblongata; later on, when Meynert's fibers become engaged, we have the Argyll Robertson pupil." "The very minute pupil often seen in tabes dorsalis is probably due to secondary contraction of the sphincter pupillæ. Argyll Robertson first pointed out, that in tabes dorsalis the pupil, although contracted and responding to light but slightly or not at all, contracts on convergence of the visual axes (or accom-

modation). He explained this phenomenon as being due to paralysis of the cilio-spinal nerves, which he therefore regarded as the nerves supplying the sphincter iridis. Raehlmann points out that the myosis and the motor phenomenon are not directly connected; for it sometimes happens that pupils which do not react to light, and do contract on convergence, are not habitually contracted, and may even be somewhat dilated. The two symptoms are, no doubt, often present together in tabes. The myosis is a sign, and an important one, of disease of the posterior columns, while the defective reaction to light with retained contraction on convergence indicates disease at some distance from the spinal cord, namely, in Meynert's fibers; and this is probably the correct explanation of the Argyll Robertson symptom. Disease in Meynert's fibers, however (as also disease of the optic nerve), may be in direct connection with disease of the cord, Stilling having found fibers passing directly from the optic tract into the crus cerebri. Raehlmann and Drouin regard myosis as one of the earliest symptoms of tabes, while Vincent does not. Raehlmann also thinks that, perception of light being present, if the pupils do not react to light, while they do contract on convergence, the symptom is usually one of serious central disease. Paralytic myosis is also found in general paralysis of the insane. In acute mania the pupil is usually much dilated, and when this mydriasis is changed for myosis, approaching general paralysis may be prognosticated. Myosis, following on irritation mydriasis, is also found in myelitis of the cervical portion of the cord. In bulbar paralysis, if paralytic myosis occurs, the disease is probably complicated with progressive muscular atrophy, or with sclerosis of the brain and spinal cord."

"Hirschler states that he has frequently noticed a contracted pupil in alcoholic amblyopia, due probably to an affection of the medulla oblongata, possibly fatty degeneration. Myosis may also be due to paralysis of the cervical sympathetic, which may result from injury, from pressure of an aneur-

ism of the carotid, innominate or aorta, or from pressure of enlarged lymphatic glands. In apoplexy of the pons varolii myosis is present, but it is not yet certain whether it is an irritation myosis or a paralytic myosis."

"*Mydriasis* may be caused by a diseased process giving rise to irritation of the pupil-dilating center or fibers, or by paralysis of the pupil-contracting center or fibers."

"The former is termed irritation (or spasmotic) mydriasis, and, according to Lesser, is characterized by a moderately dilated pupil, contracting somewhat to light and on convergence, but not dilating on sensitive or psychical stimuli, easily dilated to maximum by mydriatics, but with difficulty contracted to maximum by myotics. The latter is called paralytic mydriasis, and in it there is a moderately dilated pupil reacting to sensitive and psychical stimuli. The reaction to light and on convergence varies according to the seat of the lesion. If the latter lie between the iris and pupil-contracting center, the direct and consensual reaction to light is wanting, as is also the associated motion on convergence of the visual lines. But if the lesion lie between the retina and the pupil-contracting center, the direct contraction to light is wanting, but the consensual contraction and that on convergence retained. In either case the pupil can be dilated to maximum by mydriatics, but not contracted more than to medium size by myotics. Irritation of the pupil-dilating center and paralysis of the pupil-contracting center, existing simultaneously, give rise to maximum mydriasis. In it there is absolute immobility to stimuli of all kinds except strong myotics, which may bring it back to the normal size."

"Irritation mydriasis occurs: (a) In hyperemia of the cervical portion of the spinal cord and in spinal meningitis. (b) In the early stages of new growths in the cervical portion of the cord. (c) In cases of intra-cranial pressure, according to Raehlmann, although Lesser points out that these may also give rise to paralytic mydriasis. (d) In the spinal irritation of chlorotic or

anemic people after severe illness, etc. (e) As a premonitory sign of tabes dorsalis. (f) In cases of intestinal worms, owing to the stimulation of the sensitive nerves of the bowel, and sometimes in other forms of intestinal irritation. (g) In psychical excitement, for example, acute mania, melancholia, progressive paralysis of the insane (often then unilateral with myosis in the other eye)."

"Unilateral mydriasis occurring at short intervals, now in one eye and now in the other, is, according to Von Graefe, a premonitory sign of mental derangement. Von Graefe observed madness in the form of *manie des grandeurs* to come on some months after the occurrence of this symptom."

"Paralytic mydriasis may be due either to a paralysis of the pupil-contracting center, or as the result of the stimulus not being conducted from the retina to that center. It may be found under the former circumstances: (a) Sometimes in progressive paralysis where at first there was myosis. (b) In various diseased processes at the base of the brain affecting the center of the third nerve. (c) In a later stage of thrombosis of the cavernous sinus. (d) In orbital processes which cause pressure on the ciliary nerves. (e) In glaucoma. (f) In cases of intra-ocular tumors which have attained a certain size."

"In paralytic mydriasis due to non-transmission of the stimulus of light to a healthy pupil-contracting center and nerves, contraction of the pupil will take place only on convergence of the visual lines. The same condition of pupil will be found if the lesion lie in the course of Meynert's fibers, although vision may be normal. If the lesion lie in the center of vision (angular gyrus, etc.), or in the course of the fibers connecting this center with the corpora quadrigemina, although absolute blindness exist, the reaction of the pupil to light will be perfect. Paralytic mydriasis due to non-conduction of light stimulus is found in most cases of optic atrophy."

Of diseases of the optic nerve and retina, I saw in the two years one hundred and

eight cases. Three cases of embolism of the central artery of the retina, diagnosed, enabled me to prognose the possibility of embolism in other and more dangerous portions of the economy.

Inflammation of the optic nerve and retina, with fatty degeneration of and hemorrhages into the latter, enabled me to diagnose serious disease of the kidneys, and prognose death within twelve months. Two cases of neuro-retinitis albuminurica enabled me to diagnose Bright's disease, which did not show in the urine for some months afterward, both cases dying in less than eight months of Bright's disease of the kidneys.

Thirty-two cases of atrophy of the optic nerve in its different stages enabled me to give the connecting link in the diagnosis of many obscure diseases of the brain. Add to these, cases of hemiopia or hemianopsia and thirty-six cases of optic neuritis and neuro-retinitis, a majority of which were the first symptoms of disease of the brain and cord noticed, their importance can be realized.

How many cases of cerebral hyperemia, with its symptoms, nausea and vertigo, cerebro-spinal irritation, chorea, etc., are represented in twelve hundred and thirty-nine cases of errors of refraction, my record-book does not show. As a cause of these and other more serious affections, they are most common. Headaches from this cause, we all know, are exceedingly common. Such headaches often have no regular time for coming, no regular time for cessation; often have no symptom by which the patient's attention can be called to the eye as a cause. Only to-day I had a lady in my office from Winchester, Ky., who has for years been an intense sufferer from headaches, sometimes every two weeks, and again every week or every four weeks, who had never suspected her eyes as being the cause. While treating her daughter, she commenced boasting about being forty-seven years of age and having never needed spectacles. Her vision was only  $\frac{2}{3}$  of perfect. She had a high degree of mixed astigmatism. Her near-sighted meridian had enabled her to do without glasses for reading. She was much surprised to see how

glasses improved her vision. I believe they will relieve her headaches. This is only one of many.

Of these 1,239 cases of errors of refraction, 571 were hypermetropia, 238 hypermetropic astigmatism, 146 comp. hypermetropic astigmatism, 136 myopia, 49 myopic astigmatism, 76 comp. myopic astigmatism, 23 mixed astigmatism.

LOUISVILLE.

### TRIPLE AMPUTATION—RECOVERY.

BY A. J. BANKER, M. D.

On the morning of July 26, 1881, Peter Grass, a healthy adult, was caught under the wheels of a moving railway car, crushing both legs midway and the right hand across the metacarpal bones. He was taken on the train six miles to his home, where I saw him. He had lost quite a quantity of blood and was in profound shock. Under stimulants and opiates, by four o'clock, P. M., reaction though still partial was, I thought, sufficient to allow me to remove both legs just below the knee and the hand at the wrist-joint. Amputation of the legs was done quickly; but in my efforts to save a portion of the hand, if possible, but which proved unavailing, some time was lost.

For the succeeding twenty-four hours it seemed almost impossible for the poor fellow to live. At the end of this time, however, improvement slowly came on and recovery proceeded uninterruptedly, not seeming to be delayed by the loss of a portion of one of the anterior flaps, which, it happened, was too much bruised to live.

The wounds were dressed with balsam of Peru and antiseptic gauze, which was kept continually wet with warm carbolized water. In the extreme hot weather, and the amount of handling after the receipt of injury, together with the loss of blood, it seemed almost a miracle that he recovered.

In view of the extent of the original injury, the additional hurt done by the act of moving him home, and the three amputations made in immediate succession, Peter Grass' recovery is certainly extraordinary.

COLUMBUS, IND.

## Societies.

### LOUISVILLE SURGICAL SOCIETY.

Stated meeting, February 11, 1889, J. M. Mathews, M. D., Vice-President, in the chair.

The essay of the evening, subject, Bubo, was read by Dr. E. R. Palmer.

I have, after due reflection, chosen the subject of Bubo for my paper for this evening, not particularly because I have any thing new to present, but rather that by inciting discussion upon a subject of such general surgical interest I may bring out points of value through the experience of the members present. The term *bubo*, like the term *vaccination*, has a much broader meaning than the etymology of the word suggests. In the full significance of the term glandular enlargements, venereal and non-venereal, in the groin or elsewhere are generally included. It is my object this evening, however, to direct attention to *bubo* under the original meaning of the word, to diseases of the inguinal glands of a usually inflammatory and more or less specific type. The division of such lesions into idiopathic, inflammatory, virulent, and indolent, that was made quite half a century ago, is still practically retained, though modern surgeons, indeed scientists, generally object to the term idiopathic as applied to any thing tangible. Under this heading are classed buboes from corns, from injuries, from gonorrhea, from struma, and from various unknown sources or causes, whose unknowableness quite frequently is dependent upon carelessness upon the part of the examiner. To say that an adenitis may arise without a cause is so manifestly an absurdity, that the term idiopathic may be practically done away with—leaving us the three classes, inflammatory, chancreoid, and syphilitic.

All buboes are primarily and practically non-suppurating or suppurating, and the latter are primarily considered inoculable or non-inoculable. Secondarily, buboes are, if they persist, indices of the physical states of the sufferer, whether they be specific or non-specific; and their improvement or retrogres-

sion, with or without the best of local treatment, is always a correct gauge of the general health of the individual sufferer. Buboes of fourteen to twenty years' standing are striking illustrations of this statement.

Indolent *bubo*, in the proper limiting of that term, is the symmetrical multiple, non-suppurating *bubo pleiades* of syphilis. Of such, according to Fournier, less than two per cent suppurate; and it may be safely said that of this per cent, in a large majority of instances, the suppuration is the result of intercurrent inflammation of the primary sore (chancre), not infrequently due to the caustic applications of meddlesome surgery. A purely inflammatory yet suppurating *bubo*, with its non-inoculable pus, is *per se* a comparatively simple matter, provided, as is rarely the case, such a condition is brought about in a healthy man. A purely chancreoid *bubo*, big inguinal chancreoid though it be, is also a comparatively simple affair to deal with if it occur in an otherwise entirely healthy subject. All buboes that are treated with any thing like rational treatment are comparatively simple affairs *per se*, whether they suppurate or not; and, whether virulent or non-virulent, their persistence as phadema, or as peradenitis, is in either instance due to a constitutional dyscrasia, and that dyscrasia is usually either struma or syphilis, the latter not of the existing ulceration and inflammation, but preceding it usually some years, as does also the strumous diathesis where it takes a part.

Virulent or chancreoid *bubo* is unquestionably the commonest variety of suppurating inguinal adenitis. According to Bumstead, in his edition of 1861, there are thirty-five suppurating buboes to every one hundred cases of chancreoid in the male, and fifteen to every hundred in the female. It is not my purpose to show the decrease in this percentage accomplished by modern antiseptic management. It is, however, a matter of no little interest, in this day of specific microbes, to note that such men as Taylor and Sturgis and Kaposi deny that there is any such thing as specificity either in origin or nature in the chancreoid virus

that is therefore in the chaneroid. Why some chaneroids should be followed by suppurating inguinal glands, and others not, is a fact as hard to explain as why a very simple chaneroid is sometimes followed by a fearfully incursive and obstinate phadenic bubo. Possibly the former may be explained by the theory of some fortuitous occlusion of the lymph ducts between the primary lesion and the inguinal glands; but an equally if not more rational explanation in the other case, namely, the phadena, lies not in the nature of the virus, be that what it may, but in the constitution of the sufferer, vitiated by some generally acting cause or causes, and of these the chief, as before stated, are syphilis and struma. Any one who has begun the management of a simple single adenitis from a trifling and often non-venereal sore, only to find it persisting and daily growing more and more grave in its nature, or any one who has had like experience with inguinal phadena, will agree that the common tendency of these diverse affections to become obstinately chronic must be due to some connection direct, and therefore always ready to become manifested between a constitutional obliquity on the one hand and the great absorbent system on the other. I perhaps lay too much stress upon this constitutional factor; if I do, it is because of the large stress that is laid by authorities upon the minutiae of local treatment—the manner of opening, of curetting, of cleansing and disinfecting, of stimulating and cauterizing, of packing, bandaging, etc.; and then because of the fact, that after observing all of these matters of the law, line upon line and precept upon precept, I am to-day left with an array of uncured cases, most of which have grown from simple beginnings to be most serious affairs not only to myself, but, what is more, to the patients as well. In forcible illustration of what may come of an exceedingly simple adenitis under adverse constitutional influences, I have to present to your notice this evening several of my cases under treatment at the present time.

CASE 1. G. B., occupation, painter of coffins.

First seen in June, 1888. He had a bubo of the left groin as large as a goose egg. The entire convexity of it was as purple as the wall of a bubo could be. He had the history of a chaneroid, that had healed, and a rapidly progressing inguinal abscess, which, when I opened it, discharged a large amount of dark, ugly-looking pus. I directed it to be cleansed with hot fomentations until morning. The next morning the abscess was cleansed with a solution of bichloride of mercury (1–2,000), packed with iodoform, and a moist dressing applied over it. The wound healed very rapidly. In this case the recovery was so complete that a white line marking the point of incision was the only relic of the bubo. I might say, in this connection, that the German treatment in such cases is to remove the entire cap of the bubo and enlarge the sore.

This young man simply serves to illustrate a typical chaneroidal affection of the groin, in which an ideal result was secured, notwithstanding the ugliness of his condition.

CASE 2. The next is a case which I will exhibit. The patient, a young man, married several years, and whom I knew before marriage, never had syphilis, but had gonorrhea when a boy. September last, he had a swelling to come in the groin. He went west on a visit to his wife's relatives, on a hunting trip. The enlargement continued, and he came home and placed himself under the care of his family physician, who first painted it with iodine; when he found the glands enlarged he ordered it poulticed.

Under advice the patient left the family physician and fell into my hands. So far as I could learn the trouble commenced with simply stepping from a street car. He is in average good health. Was treated first with spica.

The question of suppuration was in doubt, but by the 2d of December the evidence of pus was so manifest and the enlargement so considerable, that it was freely incised and curetted under cocaine. Moist dressing, iodoform, and a spica were used.

He was considerably run down, had one or two rigors, and was given quinine frequently, followed by Heller's elixir. The wound healed

rapidly and the spica was removed, when it was found that two sinuses remained. These were curetted and washed out with a solution of bichloride. After that the wound was washed with peroxide of hydrogen (seven volumes), followed by bichloride wash, moist dressing, iodoform, and the spica. The wound improved, but continued to discharge until one day, groping about with a probe, I carried the instrument clear down into the scrotum. He had fallen off in flesh, and was put upon ferruginous preparations. He has since improved greatly. This is a case which I am positive has no specific element whatever.

CASE 3. The next is a case about which I am not so positive in my assertions as regards specific trouble, but all he had when I saw him first was a simple balanitis, which got well in four or five days, being followed by a bubo. A question in this case comes up at Dr. Bloom's suggestion, it is, that he had considerable stranguy. He had no history of any recent gonorrhea, but came to me, December 22d, with balanitis and a small bubo in left groin.

On January 10th the bubo was curetted and dressed. There was considerable pain after the operation, which was quieted by a hypodermic injection of morphine. On January 29th I thought best to operate, and made an incision two and one half inches long, and washed the groin out with peroxide of hydrogen (seven and one half volumes), followed by bichloride, 1-500.

At this time he left the city, and I did not see him for some time. On his return the same condition presented, and by examining with a probe I found it was simply the bulging mouth of quite a deep sinus. He is a brass-molder by profession, and had run down considerably in health. He has given no history of any venereal trouble of recent date. He had nothing but a simple balanitis.

CASE 4. Young man, twenty-three years of age, a clerk in a railroad office, came to me January 3, 1887. I saw he was nervous, delicate, and anemic. He had some prostatic irritation, no specific disease. I examined him with a urethral sound (caliber thirty-six, contraction thirty-two, and about three-inch leak).

He was given the triple valerianate pill. He was constipated, and got an aloin pill.

On April 24th he came back with gonorrhea, and got a bisulphate-of-quinine wash. On October 13th he got Robinson's phosphoric elixir, three times daily, and monobromated camphor at bed-time.

On June 6th he got Heller's elixir. Still having a little gonorrheal trouble, he got Lafayette mixture and then quinine bisulphate.

On May 29, 1888, he got Lafayette mixture, then sandal-wood capsules.

On August 2d he reported practically well, but still failing in health.

On September 16th he returned with six chancroids; boric solution was applied, and on the 17th he got boric acid internally and moist bichloride dressing. The sores were well on 17th of October last.

On December 11th he returned with an enlargement in the groin, which proved to be strumous adenitis. The groin was opened and dressed. It continued to suppurate, regardless of washes with peroxide of hydrogen, antiseptic dressing, and curetting. A counter-opening was made and a drainage-tube put in, but he got worse. The spica was used without improvement, and he was then put on the iodide of potassium.

Now, the question is, why have these inguinal abscesses resisted all treatment and continued to remain unhealed?

#### DISCUSSION.

Dr. A. M. Cartledge: I have been especially interested in these so-called idiopathic buboes, and I have come to the conclusion that they belong to the same blood state which produces enlarged glands in other localities, and that we must call them "idiopathic" for want of a better name.

There is one thing in regard to the first and second cases: It has been my observation that, in these old cases of bubo with a number of sinuses, the mere curetting of the sinuses does not cure them, even though you get to the bottom. I believe they must be cut away, and I think this is what Dr. Palmer will have to do.

As to the case in which the sinus ran down

into the scrotum, I have never seen the like. That it should have healed so rapidly speaks well for the antiseptic treatment.

Dr. Rodman: I fully agree with Dr. Palmer in his remarks. I think it is not rational to speak of these cases as "idiopathic" buboes. I have had a number of such cases in the last year, and I think I could usually trace the cause of the trouble to violence.

There are two points in the treatment of buboes of which I wish to speak: the first is the value of compression in the early stages of these idiopathic buboes. We would, of course, expect this measure to do much more good in idiopathic buboes than it would in the chancroidal. The value of compression, I believe, was first noticed years ago in this way, that persons who were in the habit of wearing trusses were not liable to have bubo, even with venereal trouble—that the pressure of the truss prevented them—and that led to the introduction of compression in the treatment of these cases. In my experience I have been very well satisfied with the treatment by spica of the groin, making very firm pressure. It seems to me that I have aborted buboes of this kind both in private and dispensary practice.

There is one other point, it is the time at which these buboes should be opened. Contrary to all the teachings on the subject, I do not believe it is proper to lance them as early as fluctuation can be elicited. The teaching is to open as soon as you detect pus. I do not believe that is good treatment in the chancroidal bubo. The reason is this: The poison is taken up by the lymphatics, and of course carried to the gland, and this poison, whatever it is, is deposited in the substance of the gland, sets up inflammation within the gland, and then, by contiguity of structure, you have the cellular tissue around the gland inflamed. The point is this: You will have suppuration sooner in this cellular tissue around the gland than you will have in the gland itself, and if you make an incision as soon as you detect fluctuation in this tissue around the gland, then when the gland itself breaks down you will have the whole wound re-inoculated with the chancroidal virus. I think it is better to do one of two things: If you operate early

the entire gland should be removed. I do not think you do any good unless you do. The virus is so virulent that if you do not remove the entire gland you will inoculate the whole sore. The second is, if you do not remove the whole gland the operation should be delayed.

Dr. I. N. Bloom: I agree with Dr. Palmer on the whole, but take issue on one point. I do not believe in an especial virus of chancroidal bubo.

I do not agree with the Doctor as to the fact of especial dyscrasia in bubo, at least to the extent that the Doctor speaks of. I have seen buboes occur with as little cause in strong, healthy individuals as I have in the broken-down ones. I have seen them occur under all circumstances with almost as little cause in the one as in the other, and with equal severity.

As to treatment, I think the mistake most generally made is doing too little, not too much. Individually, I have not had a single case of any sinus, and never had any difficulty in getting union. Whatever success I have had I attribute to the fact that when I open I take out every bit of gland and leave the whole sore perfectly free and clear. I then pack it with iodoform, and let it remain for three or four days at least, leaving no pus or thready tissue behind. In the last two cases, I think temporizing is a great mistake. I should not hesitate to advise a radical scratching out; scratch out every bit of diseased tissue, dress the wound, and do not look at it for four or five days. I believe, if you operate at all, you should operate radically, and in general you will fail to get the conditions these patients have shown.

In a recent medical journal I read an article wherein were reported two or three hundred cases, in which this treatment was shown to be *par excellence*. If there is an inflamed gland in the neighboring region, extend the incision to this gland and scrape it out.

In regard to aborting buboes, I do not think there is such a thing, after the gland begins to swell, whether it is a simple or virulent bubo; whether you make cold applications, apply poultices or pressure, compound or simple tincture of iodine, or any thing else, the gland

will be entirely uninfluenced by it. I have been able to convince myself of this fact by using all these means, and still the buboes have gone on to suppuration. I have had cases of double bubo, and on one side tried the abortive treatment, and on the other side done nothing, with the same result.

Dr. J. M. Mathews: Do you mean by aborting, that you can not prevent suppuration?

Dr. Bloom: Yes, sir. I mean that the treatment has no influence upon suppuration. In many cases, in spite of any thing you can do, they will go on to suppuration.

The especial emphasis that I wish to make, in speaking of this, is the great danger of doing too little instead of too much.

As to time, that is a matter of opinion. I have many times opened a bubo without having previously detected any marked fluctuation. The most recent treatment has not been mentioned. I have had no experience with it. It consists in making an incision, scraping out the gland, washing it, and drawing the sides of the wound together, and letting it heal by first intention. I have a very indistinct recollection of having read, six or eight months ago, of that treatment having been tried with no better results than others, because in a few cases it will heal by first intention; in others it will break down again and heal by a secondary union.

As to the time required for cure, I take an average from the time I make the incision to the time I take off the bandage, and tell the patient he need not come to see me any more. I consider I have done good work, if this can be accomplished in twenty-eight days.

Dr. Turner Anderson: I advanced the idea, at the last meeting of the Society, that these cases were occasionally idiopathic. I suggested this simply because I had nothing better to offer, and I see cases which I am unable to trace to any specific infection. I remember several years ago we had quite an epidemic of what were recognized as "idiopathic" buboes. At the present time I have two cases of bubo which I am unable to trace to any specific cause; that is, relying upon the statements of the individuals. In one of these cases, a man who seems to be in very good health has an enlargement in the groin, and has a bubo, which I lanced

after getting fluctuation, but without deriving any special benefit. Above it, and not connected with the abscess which I lanced, he has another abscess which is pointing. I concluded to let that alone, believing, perhaps, I had opened the other too early, and that if I had waited a little longer there might have been communication between the two. He is a married man, very healthy, and has no history of infection of any character. I have recognized it as an idiopathic inflammation.

With reference to the treatment of these cases, I think that a very free incision is necessary. I do not know that I understand Dr. Palmer in regard to what he means by "curettling" buboes. I have never used the curette in treating a bubo. My plan has been to wait until I had distinct evidence of fluctuation; then to make an incision, and afterward introduce a grooved director and split up the skin; then with my finger turn out the contents of the abscess, and dress it antiseptically. My results have been very satisfactory.

I have an experience in regard to a case which occurred ten or twelve years ago, before antiseptics came generally into use. A man had a bubo of this character, and a very small opening was made into it, simply to allow the pus to discharge. There was a large amount of suppuration, and a very considerable amount of sloughing occurred as the result of the bad treatment of the case. The cellular tissue surrounding the gland in the groin became involved, and finally the necrotic process extended until the femoral artery was laid bare. Of course we recognize how nature provides against the opening of arteries under these circumstances. Under the treatment that was instituted I got arrest of the necrotic process, and finally union, the case terminating satisfactorily.

I believe we have the lymphatic glands in the groin affected just as we have the cervical glands. They may become inflamed and suppurate. I can not understand why calcareous degeneration might not take place and the salts of lime be deposited, just as we see it in the cervical glands. Another result may be caseous degeneration of these glands, just as this takes place in the lung.

Of late years, in treating these abscesses, when I feel it necessary to interfere surgically, I make a free incision and then introduce my finger and gouge out the material, removing it as well as possible, and packing it with iodoform or boric acid. I generally allow such cases to go about, not even putting on a bandage. I treat so few of these cases, however, that I want to be understood as speaking from the standpoint of a general practitioner. I want to be placed on record as saying that idiopathic adenitis is not an unusual affection, whether occurring in the cervical, axillary, or inguinal glands.

Dr. Matthews: What I have to say does not relate to the treatment of buboes *per se*, but there is such a strong analogy between affections of this kind and fistula in ano that I am constrained to say something. First, as to the question brought up by Dr. Rodman as to when we should lance a bubo. He puts himself on record as saying that even when he detects pus he does not believe it always good treatment to open the chancroidal bubo.

If we compare these abscesses (for where a cavity contains pus, that is an abscess) with a rectal abscess, it is certainly contrary to all the teachings I have ever heard. I believe the surgical acceptance is that whenever pus is found it must be given vent. The reason for this is very plain. If pus is confined in a bubo, in a rectal abscess, or in an abscess in any locality, if it is not given an exit, it seeks an exit. If it does not come toward the skin and force itself externally, it will burrow, and you will get the solution of these three cases of Dr. Palmer's. Why is it that these three cases have not been cured? I think I can get at the solution. I should say that in every single instance where I could detect pus, and sometimes, I believe, even if I could not detect pus, I would make an incision. Certainly, if pus be present it should be let out. Pus is the cause which produces that morbid condition which prevents buboes from healing. To illustrate: Take an abscess around the rectum or anus—that is, a pus cavity. The treatment is that it should be cut into and let out. If we see that abscess in time we can safely say to the patient, "I can prevent fistula." If

we do not see it until it is ready to open of itself, we say, "You are likely to have a fistula in ano."

The reason these sinuses do not heal is because in every single sinus is, what for want of a better name I will call a form of pyogenic membrane. We know that every single irritant we employ is not sufficient to destroy this pyogenic membrane, and therefore it is not recommended to inject these substances for the reason that it is not sufficient to effect a cure.

Dr. Palmer has asked why it is these buboes have not healed? I take it is not because of diseased gland or soft tissue, because this has all been cleared away, but because there is a source of irritation left which prevents the healing, and that is the sinus. In every one of these cases he takes a probe and runs it through these sinuses, and the injection which he uses, whatever it is, has not been sufficient to set up a healthy action in this pyogenic membrane. To illustrate: In operating upon fistula in ano, for years it was the custom to introduce a grooved director and slit it up. It was found by actual observation that that was not sufficient to cure fistula, hence is known in surgery the back cut of Mr. Shannon. To conclude, I believe that in these cases Dr. Palmer has accomplished the major part, but before he will have these buboes cured he must slit up every single sinus that now exists.

Dr. Palmer, closing the discussion, said: I wish to say, in reference to the three cases, I believe Case No. 1 will get well without any further use of the knife. The evidences in that direction are such as impress me from long watching of the case. This is the case I operated on months since. It was seen the next day by Dr. Cartledge. I certainly did as thorough and complete removal of every sinus and diseased tissue as possible. He has had a good many ups and downs, but is going to get well.

Case No. 2 will get the knife to-morrow, and I shall attempt with curetting to relieve the case without a very extensive removal of that long roof of healthy tissue that is there. I do not believe, from the surrounding tissue, that the case demands as free an opening as would

be made by the removal of that large piece of healthy tissue. Still, I can tell better when I enlarge my counter-opening.

Case No. 3: We were all ready once to make a free operation and remove every thing, but the young man has been in a very bad condition. He is very nervy. He would stand right up and let you cut his limb off, but he has been in such a bad condition of health that I thought I would delay somewhat, but now that he has improved, I think in about two weeks he will be in condition for a very extensive operation.

Some years ago, when I was doing general practice, I congratulated myself upon going through several seasons of typhoid fever without losing a case, but the next season I lost my first nine cases. For some years I have had no trouble with buboes, but this has been my off season.

In regard to removing dressings: It is my rule never to remove a dressing until I have to. It is only when dressings get loose that they are removed. Certainly no one believes more in thorough packing or in letting wounds alone than I do.

M. G. Taylor is the American authority in the abortive treatment of bubo. His treatment is injections of one-in-thirty of carbolic acid. He claims this almost a specific against suppuration, but says, if suppuration occurs, draw off the pus and then inject again. Some authorities advise cutting the buboes very early. I have done that and also the delayed operation. I have been delaying in some cases upon the principle that Dr. Rodman has stated, but I am afraid that in some of these cases the delay has been the cause of the sinuses.

Dr. Mathews says that pus is always the cause of this trouble. I do not believe that pus will account for the condition of Case No. 3. The point I made was that the condition of these patients is more dependent upon an especial dyscrasia than upon the mere confinement of pus. Why it is I should have this trouble I can not say. Certainly I can not believe it is any fault in the surgical or local treatment of the trouble.

E. R. PALMER, M. D.,

*Secretary.*

## Reviews and Bibliography.

**Pictorial History of Ancient Pharmacy**, with Sketches of Early Medical Practice. By HERMANN PETERS. Translated from the German and revised, with numerous additions, by Dr. WM. NETTER. Pages, xiv +184. Price, \$2.50. Chicago: G. P. Engelhard & Co. 1889.

Although one can not well arise from the reading of this book without a sickening sense of disgust at the ignorance and superstition of Christendom through the long night of the Dark Ages, it may yet be read with profit. It shows how much of the intellectual liberty and light of to-day we owe to science, and especially to the learning of the Greeks that broke upon us from the Arabians during the crusades. How long ecclesiastical greed might have kept the world within the pall of Middle-Age darkness, had not the crusades brought back the glimmering light of Grecian philosophy, no one can tell. Well may we, who delight in the intellectual liberty of to-day, thank Peter the Hermit for the "enemies he made."

When we consider also that the jargon, the fetishism that make up this showing of medieval medicine are the islands in the slough of ignorance, it may well lead us to consider our present standing-ground, and to ask ourselves if we do not now admit and laud much that the enlightened intelligence of the future may spurn as we spurn so much of the past. The book is well worth reading for what it can not tell.

D. T. S.

**The Pathology and Treatment of Displacements of the Uterus.** By B. S. SCHULTZE, Professor of Gynecology, Director of the Lying-in Institution and of the Gynecological Clinic in Jena. Translated from the German by JAMES MACAN, M. R. C. S., etc., and edited by ARTHUR MACAN, M. B. With one hundred and twenty illustrations. Pages, viii+378. New York: D. Appleton & Co. 1888.

The attention of gynecologists has, of late years, been so much absorbed by the important advances made in the operative treatment of diseases peculiar to woman,

that some other departments of this specialty have been thrown somewhat into the background. For nearly thirty years, from 1852 to 1880, great expectations were entertained from the "orthopedic" treatment of the uterus as practiced during that period, and often indeed great results were derived. It is clear to the most casual observer of the present day, that neither have these expectations been realized nor the supposed results confirmed. On the contrary, the conviction has been steadily gaining ground that this treatment was not based on the requisite etiological knowledge, and the requisite knowledge of the normal position of the uterus indispensable as a foundation of any proper plan for the correction of its anomalous positions.

No one has done more to correct the evils and to supply the short-comings in question than our author; and, from being at first bitterly criticised, he has taken his position as one of the ablest and most judicious teachers in his department of medicine.

The work is one that no gynecologist can well do without, and one valuable to the general practitioner in particular.

D. T. S.

**A Compend of the Diseases of the Eye;** including Refraction and Surgical Operations. By L. WEBSTER FOX, M. D., Ophthalmic Surgeon to Germantown Hospital, etc., and GEO. M. GOULD, M. D. Second edition, revised and enlarged; with seventy-one illustrations. Philadelphia: P. Blakiston, Son & Co. 1888. Price, \$1.00.

The second edition of this compend, appearing within a year after the first, shows that it must meet the demands required of such books. The authors state that the purposes endeavored to be fulfilled are, (1) to supply the medical undergraduate with the most noteworthy points concerning the diagnoses and treatment of ocular disorders, whether pathological or refractive; (2) to give the busy practitioner, who has never considered the importance of this knowledge to himself, or has relied on his neighbor, the oculist, a few outlines of the science. The first purpose, it seems to us, the Compend fulfills most admirably. The second, it would seem, requires a more

extended and elaborate study than can be found in a book of the size. The student can get many ideas from this little work that will be of value to him during his college days; but when he becomes a practitioner and takes under his care cases of eye disease, if he be a conscientious practitioner, he will send his patient to the oculist for treatment rather than rely on information derived from such an abbreviated study of the diseases of the eye as are in the Compend for his guidance. To the specialist, who is accustomed to rapidly review most books of this class, many excellent points will be noted. This is especially true of the first fifty-four pages, devoted to refraction, the ophthalmoscope, and the adoption of lenses. The authors have a quick, terse, and attractive way of stating facts and drawing conclusions. This is especially noticeable in a series of ophthalmic aphorisms found at end of the book. I commend them to every one interested in the eye as most excellent maxims.

The formulæ at the end embrace all of real importance in ordinary practice. I commend the book highly to students wanting a short and compact work.

J. M. R.

**Lectures on Ectopic Pregnancy and Pelvic Hematocele.** By LAWSON TAIT, F. R. C. S. (Edin. and Eng.), LL. D. 107 pp. Birmingham: The Journal Printing Works. 1888.

Lawson Tait is a man who never speaks without attracting attention, and seldom he disappoints it. These lectures are no exception to the rule, howbeit many will be found who will not accept his views in their entirety.

Tait insists that the fallopian tubes are not rudiments of the cornua of the bicornate uterus, and that instead of fecundation of the ovule occurring in the outer third of the tube, as taught by nearly all original investigators, it occurs invariably in the uterus, except when the epithelium has been pulled off from the lining of the tube by disease or abnormal action.

As to the first position, that the fallopian tubes are not rudiments of the cornua of the bicornate uterus, aside from the teach-

ing of morphologists, who ought to be the most competent authority, the arrangement of the internal circular fibers of the uterus show such a relationship, for around the insertion of the fallopian tubes a circular arrangement of these internal muscular fibers strongly point to such rudimentary relation.

The contention that fecundation takes place in the uterus alone is based upon no sound argument, while the direct observations of Von Benedon and others place beyond controversy the fact of fecundation taking place in lower animals in the outer third of the tube.

Passing over these points, in which we do not consider Tait an authority, to others in which we do so regard him, we find no clearer presentation of the subject of ectopic pregnancy and its relation to hematocele. His treatment of these subjects is extremely interesting and very satisfactory. D. T. S.

**The Life Insurance Examiner.** A Practical Treatise upon Medical Examinations for Life Insurance. By CHARLES F. STILLMAN, M.S., M.D. Pages, 201. New York: The Spectator Company. 1888.

This is beyond all comparison the most helpful work we have seen on the subject of life insurance. The author is himself a physician of large experience in matters of the kind, and is beside evidently a man of affairs. To the beginner, especially, it must prove of very great assistance, and even those of experience might peruse its pages with profit. D. T. S.

**Treatise on the Diseases of Women,** for the Use of Students and Practitioners. By ALEXANDER J. C. SKENE, M.D., Professor of Gynecology in the Long Island College Hospital, etc. With two hundred and fifty-one engravings and nine chromo-lithographs. Pages, xiv—966. Price, \$6.00. New York: D. Appleton & Co. 1888.

This treatise, one of the latest, and by an author whose opportunities have been among the very best in the land, would justly be expected to contain whatever is valuable in its particular scope. This, in-

deed, it does. It also contains a larger number of detailed case reports than is customary in recent works, and than most thoughtful readers may think necessary. This is largely compensated for by leaving out the historical references that tediously fill up so many pages of special works, an example that it is hoped will find abundant followers, and that in the future special works will be devoted to the authors of discoveries and inventions, leaving only those that mark epochs to be put into text-books.

The book before us adds another to the number of good works on the subject of gynecology from which the student may choose. D. T. S.

**Hand-book of the Treatment of Skin Diseases.**

By ARTHUR VAN HARLINGEN, M. D., Professor Diseases of the Skin in Philadelphia Polyclinic. Pages, ix—410. Price, \$2.50. Philadelphia: P. Blakiston, Son & Co. 1889.

If it were not otherwise demonstrated by recent experience, it might be judged impossible to produce a poor book at the present time on diseases of the skin. We shall insist, however, that it is easier to produce a good, small work than a poor one. There are so many well-digested works, and the treatment of skin diseases is so largely descriptive, that all one has to do is to copy well from the large store of lucid descriptions at hand, and he has a good book. The work before us is, in that light, commendable, and perhaps fully equal to any of its class. D. T. S.

**A Practical Treatise on the Diseases of the Hair and Scalp.** By GEORGE THOMAS JACKSON, M.D., Instructor on Dermatology in the New York Polyclinic, etc. Pages 356. Price, \$2.75. New York: E. B. Treat. 1887.

The aim of this book is to present to the medical profession a concise statement of what is known of the diseases of the hair and scalp, special attention being given to their diagnosis and treatment.

The treatment of the subject is full, and a bibliography of the subject, embracing several hundred authors, is appended at the close. D. T. S.

## Correspondence.

### PARIS LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Nobody had till now succeeded in reproducing in animals diabetes such as is found clinically in the human subject. MM. Germain Seé and E. Gley have more than a year conducted varied researches on this point, and presented the following observations to the Academy of Sciences: (1) It is known that the excitation of the central portion of the vagus nerve gives rise to hyper-glycemia and to glycosuria. The authors have been able to produce permanent irritation of the central portion of the right pneumogastric nerve in a dog and several animals under observation, which presented, not glycosuria but a veritable azoturia with notable and rapid emaciation; but this was only one of the elements of diabetes. (2) Dogs have been rendered glycosuric in making them ingest daily phloridzine (one gram per kilogram of the weight of the animal). In these conditions the urine of these animals contained for twenty-four hours, from the first day of the treatment, a proportion of glucose of from ten to twelve per cent. The glycosuria ceased with the suspension of the phloridzine. This interesting experiment had already been performed by Von Mering. It is the phloridzine itself that possesses this action on the general nutrition; and, in order to prove this, the experimenters got a dog to absorb the products of the division of this glucoside, or simply the first elements of these products, pure phloretine, in the same doses as phloridzine. It scarcely passed in the urine one per cent of glucose. The influence of the phloretine is so little that one must evidently admit that it was not by its phloretic radical that the phloridzine acted. It was as a special compound. Whatever alimentation the animal was subjected to, the urine contained sugar. These facts are interesting, because, as all the glycogenic matter of an animal to which is administered phloridzine is very rapidly destroyed, as was shown by Von Mering, they prove that the glucose may be formed in the organism at the expense of the albuminoid substances and of fats. This gly-

cosuria is accompanied by other troubles. The animal under experiment, at the end of some days, becomes very voracious, and if it is not super-alimented it rapidly emaciates. It may thus be seen that this glycosuria is accompanied in a certain measure by polyphagia. Abstraction being made of the presence of glucose, the general composition of the urine scarcely varies as regards the total quantity of urea and nitrogen, although the relation between the latter and urea appeared to be somewhat lowered. The authors submitted the glycosuric animals to the divers modes of treatment employed in diabetes. The two modes of treatment by the bicarbonate of soda and by arsenic proved inefficacious. The administration of the bromide of potassium produced, on the contrary, a slight diminution of glucose. With antipyrine the authors obtained a more marked attenuation of this glycosuria. For instance, a dog which eliminated, on an average, 13 grams of glucose per day, the experimenters found that in giving it 1 gram of antipyrine, the experiment having been followed up during eight days, this average fell to 11 grams, notwithstanding the mixed diet. The same animal, again submitted to observation, eliminated 9 grams 6 centigrams of sugar per day. Treated with antipyrine, it eliminated only 5 grams 7 centigrams. Another dog, very small, whose urine contained 8 grams of sugar, did not yield, in the same conditions, more than 6 grams 9 centigrams. The influence of antipyrine appears very clear, and these results are not to be wondered at, if we recall, on the one hand, that Von Mering has demonstrated that, under the influence of phloridzine all the glycogenic matter of the liver and of the muscles disappears, and, on the other hand, that MM. Lépine and Porteret, of Lyons, have recently shown that antipyrine slackens precisely the transformation of the glycogen of the liver and of the muscles into glucose. The experiments of MM. Seé and Gley combine and at the same time confirm these two experiments. M. Seé tried the action of antipyrine on a certain number of diabetic patients, and he obtained very good effects from this treatment. The authors conclude their note with the following reflection: "Being given the general action of antipyrine, which diminishes the

excitability of the nervous system, might it not be asked whether diabetes does not result more from an exaggeration than from a slackening of the nutrition? As nothing indicates the measure in which we shall be able to conclude from experimental glycosuria its proper position with human diabetes, is a question that we would simply wish to propose."

Antipyrine has been greatly vaunted as being of great utility in lessening the pains of labor, but this does not appear to accord with the experience of Dr. Auvard, accoucheur to the hospitals, who, after having cited several cases, arrives at the following conclusions: (1) To women particularly impressionable, the administration of antipyrine during labor appears to produce real relief, but more frequently very slight, due either to the action belonging to the drug, or more to the moral and suggestive influence of the hypodermic injection. (2) In the majority of cases the action of antipyrine is nil. (3) Without denying the good results which may be exceptionally obtained by the aid of this medicament, its happy influence on the pains of labor should be considered as very inconstant, and one can not in any manner put it on a parallel with chloral or with chloroform in obstetrical cases, the anesthetic power of which is now incontestable.

Dr. Lavaux read a note at the Academy of Medicine, last week, on the distant results of linear electrolysis in the treatment of stricture of the urethra. The author related that this procedure had already been employed by Mallez and Tripier about a quarter of a century ago. Some patients were cured for some time, but more frequently relapses were rapid. Dr. Lavaux, who is now in charge of the clinic of Mallez, has made researches on the patients who had undergone this operation. In all these cases there were relapses. Of thirty-five cases of linear electrolysis, there has not been a single durable success, as the radical cure of stricture of the urethra has not yet been obtained. The method of choice in the treatment of stricture consists in rapid dilatation.

Professor Bouchard proposes the following treatment for typhlitis: (1) Calm the pain, either by an injection of morphia or by the application of a thick layer of mercurial ointment

and belladonna, covered over with a large hot poultice. (2) Wash and render aseptic the large intestine by free intestinal irrigations practiced twice a day with at least one liter of water at 38° C., to which should be added borate of soda 5 grams, and two or three teaspoonfuls of the following mixture: tincture of benzoin, camphorated alcohol, of each thirty grams. (3) Absolute rest. (4) Only very mild purgatives should be employed. (5) The diet should at first consist of milk diluted with an alkaline water; later on, the yolks of eggs might be added. Antisepsy may also be insured by the stomach.

PARIS, February 8, 1889.

## Abstracts and Selections.

**DRY ANTISEPTIC WOUND TREATMENT.**—During the past three years I have treated all recent wounds on what I call dry antiseptic principles, and I am so satisfied with the method that I venture to call attention to it. The number of cases of rapid primary union which I have had, both in hospital and in private during this time, and under this treatment, far exceeds any thing I had previously seen either in my own or in the hands of others. Although I am not aware of the exact methods detailed below being elsewhere practiced, I do not pretend that they are original, and it will not surprise me to learn that many practitioners have adopted precisely the same procedures, or, at least, have been guided in their wound dressing by identical principles.

In the year 1878 it was my privilege to be a house surgeon under my late colleague, Mr. Sampson Gamgee, and I need scarcely add, therefore, that the principles which animated him in this matter of wound treatment became familiar to myself. At that time, rest, position, and pressure were extolled by him as the "Trinity of the Surgical Graces." Dryness and infrequency of dressings were his guiding rules in practice. Gamgee understood, as did Liston, Syme, Bell, Pott, and Hunter before him, those great primary and essential conditions under which injured tissues most readily heal, and his affection for old surgical authority would not allow him to be carried helter skelter away on the tide of Lister's carbolic sea. He appreciated what was sound in the Listerian method, and accepted it at once. He smiled at the "theory" and jested at the

"spray," and how far he was right the practice of many of our leading living surgeons bears ample evidence. Shortly before Gamgee's death he had included a fourth among his "Graces"—that of antiseptics—although he never attached the importance to it to which it is properly entitled.

Rest, position, and pressure are potent factors for good in the treatment of all wounds; but greater than any one of these is perfect "surgical cleanliness," another term, I take it, for "perfect asepsis." The essentials of wound treatment, therefore, constitute a party of four—a quartette—in order of importance as follows: (1) surgical cleanliness, (2) practical immobilization, (3) uniform pressure, (4) moderate elevation. Dryness of dressings I look upon as scarcely second in importance to any of the above.

Dominated by these principles, I have by degrees elaborated a method of wound-dressing which, in my opinion, nearly satisfies all requirements; but that still further improvements will be added I think is extremely probable.

I will now briefly describe my present method of operating and of subsequent wound treatment; say, for example, in an amputation through the leg. Every patient about to be submitted to any surgical operation ought to have been confined to bed for at least twenty four hours, and, whatever the nature of the operation, the bowels should have been cleared. These are points to which too little importance is often given.

The parts are shaven of hair, washed with soap and warm water, well scrubbed with a nail-brush, and are then protected with a cloth wetted with weak corrosive-sublimate lotion until the moment of operation. The patient is anesthetized, the tourniquet applied, and the limb exposed. All clothing covering other parts is protected with cloths wrung out of weak antiseptic lotions, chiefly for the purposes of shutting in the "fluff" of the blankets, dressing-gown, etc.—one of the most potent "infectors" in operations as frequently carried out—and also for laying artery forceps, retractors, etc., down upon when they are not actually in use.

The hands of self and not more than two assistants and a nurse are scrubbed with hot water and soap, care being paid to the recesses about the finger-nails (another common lurking place for septic matter). Let there be no misunderstanding as to the number of hands which are to come in contact not only with the tissues of the part itself, but, what is more important, with any thing and every thing which is to be used at any

stage of the whole operation. After these hands are cleaned, see that they are not thrust into pockets, nor used to restrain a refractory patient, by seizing other parts of his body than that which is to be operated on; for here, again, lies another source of infection. Hands are washed, but they are often recontaminated before the operation begins.

Instruments are to be thoroughly washed and scrubbed; and with regard to these I will merely mention the localities in which infective material is most likely to be overlooked: first, the teeth of artery and other forceps; secondly, the eyes of needles; thirdly, the chequered handles of knives; fourthly, the teeth of saws; and fifthly, the chains of *écraseurs*.

Sponges I never use. I fear them most in hospital practice. There is no way of assuring yourself of their cleanliness. Theoretically no objection can be sustained against them, but practically they often betray us. I use instead pieces of new lint about fourteen inches square, usually two or three being sufficient for major operations. These are swilled out in warm water by the nurse who is assisting.

When the limb is off, free bleeding points are tied with catgut ligatures. Capillary oozing is checked with hot water. I always endeavor to stay the last leaking point, but in the majority of cases I am bound to confess that I fail to secure that dryness of surface which theory says is essential to primary union. Small clots between wound areas give me no uneasiness. I have seen Gamgee shut up freely bleeding flaps and still obtain primary union. "Securing the last bleeding point" often means prolonged operation with all its evils, as well as the unnecessary bruising of tissues which follows from the inevitable "mopping" attending the discovery of troublesome points.

Before closing the wound the whole raw surface is thickly covered with finely powdered boracic acid, rubbed gently but thoroughly into the parts, attention being directed to the connective-tissue plains around muscles, vessels, and nerves. The procedure is precisely like that adopted by the cook when "salting" hams. Several drams, sometimes ounces, of the acid are shut up in the wound, and are never seen any more. The "salting" constitutes an essential part of the dry antiseptic process which has given such good results in my hands. Wound edges are sutured sometimes with silk, at others with silver; for which latter, however, I have no preference over fine iron wire.

Drainage is best arranged for when the wound is nearly closed. A finger introduced at this stage discovers the deepest, most dependent recesses, and into these large rubber drainage tubes are directed, and are brought out, as a rule, at the angles of the wounds; but sometimes special incisions are made through the tissues and skin of a posterior flap for the purposes of shortening and of perfecting drainage routes. The ends of the tubes are left several inches long, and the dressings arranged so that the ends project outside their outermost layer. In this way all early serous discharge is carried right away at once, and the tubes can be withdrawn early without removing the dressings.

The wound being closed, it is dusted over with powdered boracic acid, and covered by a single strip of lint soaked in a saturated solution of boracic acid and glycerine, outside which are placed two or three thicknesses of Gamgee absorbent tissue, cut and arranged so as to exercise equable pressure over the face of the stump and the lower twelve or eighteen inches of the limb. A simple layer of gutta-percha tissue is next applied, large enough only to extend to a point some two or three inches above the limit of the wound. The whole dressing is now secured by gauze bandages which encircle the limb to its uppermost limit. Mill-board splints, covered thickly with common wadding, are adapted outside the dressing, and are secured with ordinary bandages.

If, during the forty-eight hours following operation, temperature and pulse remain normal and pain is absent, I simply withdraw the tubes and leave the dressings otherwise undisturbed. The meddlesome inquisitiveness which directs us to expose all wounds within twenty-four or forty-eight hours, simply for the purpose of seeing how they are going on, is calculated to do a tremendous amount of harm. Not a few primary unions are spoiled by the practice. It has always appeared to me like to the child who sows seeds in her toy garden, and digs them up next day to discover what progress they have made. Recent wounds should be dressed only in response to three demands—high temperature, quick pulse, and pain. If all are absent, practice teaches me that satisfactory progress is being made, whatever theory would suggest to the contrary. In the absence of any of the above indications, I leave wounds undisturbed from one to four weeks, dressing them only to remove sutures in amputations, tumor excisions, etc., to assure myself of accurate position in osteotomies

and joint excisions, or to perform a further step in operations such as gastrostomy. If primary union is found to have taken place throughout the whole or greater part of the wound, similar dressings are again applied; but if free suppuration has occurred, I abandon dry and infrequent dressings altogether and use one of several other kinds particularly adapted to the rapid and continuous and thorough removal of purulent products. In cases with what I regard as "inevitable suppuration"—most sequestrotomies, for example—after the first boracic-acid dressing I am fond of applying pieces of coarse scouring flannel moistened with carbolic lotion (1 in 40), changed two or three times during the twenty-four hours, and continued until wound surfaces have cleaned and are covered with healthy granulations. I know no material which sucks up discharges with greater avidity.

I have used dry boracic dressings in major surgical operations of all kinds, and primary union has followed in the vast majority of cases. I have opened the abdominal cavity scores of times, the cranial cavity in many instances, and the cavities of joints on numerous occasions, and have never seen more than the merest trace of suppuration in any of the wounds.

I have had hip-joint amputations soundly cicatrized, and patients sitting up on the twelfth day. Failure to secure primary union in breast excisions comes as a bitter disappointment. I purposely avoid detailing cases in this paper, because I believe that no useful practical end would be served thereby.

My own experience of surgical dressings began at the General Hospital at a time when Listerism had attained what was considered its highest perfection, when operations were performed in a cloud of carbolic steam, and patient and operator and assistants practically swam about the theater in floods of antiseptic fluids. None among my earliest teachers had a more thorough conception of what Listerism could do, none followed the precepts of his enthusiastic leader more energetically, no disciple of the germ theory was more conscientious than the late William Preston Goodall. In his practice I gained my first experience of perfect primary unions after major operations; and without saying my present results are better than what I saw then, I am sure they are as good, and are secured with less labor to the surgeon, with less expense to the hospital, and with less suffering to the patients.

In conclusion, I would add my belief that no small measure of my success is due to

the introduction into the wound of the non-irritating, non-poisonous, and reliably antiseptic, dry, and absorbing powdered boracic acid.—*Dr. Jordan Lloyd, Brit. Med. Jour.*

**SOME VALUABLE CONTRIBUTIONS TO THE LITERATURE OF DIGESTIVE FERMENTS.**—Notwithstanding the importance and large consumption of the digestive ferments, the scientific literature relating to the character, action, and application of these agents has hitherto been very meager.

The recent improvements in pepsin, the discrepancies between the statements of different manufacturers, the confusion as to proper tests, and the real importance of these agents has concentrated on them of late the interest of physiological chemists, and much has already been accomplished in the direction of determining the digestive power and purity of various pepsins, the mode of action of this ferment and its incompatibilities.

One of the latest and most valuable contributions to the subject is a scholarly article, by R. H. Chittenden, Ph. D., Professor of Physiological Chemistry in Yale University, entitled *Observations on the Digestive Ferments*, which was read before a section of the New York Academy of Medicine, January 23, 1889, and published in the *Philadelphia Medical News*, February 16, 1889. This gives an able and comprehensive review of the whole subject, of the investigations of other observers from the discovery of the digestive ferments to the present time, and of the experiments of the author, from which he reaches the following conclusions:

"As a final result, then, we may consider the true proteolytic power of the following pepsins compared with one of the highest digestive power to be as follows:

	Relative Proteolytic Action.
1. Parke, Davis & Co.'s pepsinum purum in lamellis .....	100
2. Fairchild's pepsin in scale .....	52
3. Scheffer's dry pepsin, concentrat'd, .....	48
4. Jensen's crystal pepsin.....	35
5. Ford's pepsin in scales .....	32
6. North's pure pepsin.....	16
7. Budalt's pepsin .....	14
8. Royal Chem. Co.'s pure pepsin....	9

"As to the actual strength of these preparations, 1 milligram of the strongest pepsin converted into soluble products, 198 milligrams of the pure dry albumen, which would be practically equal to 2,000 parts of fluid egg albumen."

Among other valuable articles on pepsin

recently published, we may mention those by Dr. John R. Winslow, Lecturer on Chemistry, Women's Medical College, Baltimore, Md., entitled *Pepsin and Its Incompatibilities*, with Exhibition of Tests, and published in *Maryland Medical Journal*, February 16, 1889; *Pepsin in Surgery*, by H. B. Douglass, M. D., in *N. Y. Medical Record*, December 22, 1888; *Pediatric Points and Pickings*, by Dr. I. N. Love, in *Weekly Medical Review*, January 26, 1889; *Digestive Ferments*, by J. Leroy Webber, in *Pharmaceutical Record*, February 4th; *Comparative Pepsin Testing*, by F. A. Thompson, Ph. C., in *Druggists Bulletin*, September, 1888.

The use of pepsin has been extended to local applications in diphtheria, membranous croup, and in surgery, where the digestion of a false membrane or abnormal tissue growth is desired, and this agent is likely to play an important rôle in the future in the therapeutics of these diseases as well as in indigestion.

Those of our readers who desire to inform themselves of the latest discovered facts regarding improvements in pepsin, its incompatibilities, best methods of administration, and how to test it, should correspond with the manufacturers whose recent investigations have led to the production of the highest quality of pepsin yet produced—Messrs. Parke, Davis & Co.—who announce that they will send literature on Digestive Ferments and a sample of their pepsinum purum in lamellis to physicians free on request.

**SLIGHT AORTIC INSUFFICIENCY.**—Some instructive experiments on artificially induced aortic murmurs were published, some months ago, by Dr. Timofejew (*Berlin Klin. Woch.*), in which he showed that a very slight aortic insufficiency may exist without producing a diastolic murmur, but that here a distinct accentuation of the second sound can then be heard; he also found that with greater but still slight insufficiency, though a murmur is produced, this can be made to cease by diminution of the blood pressure, either by venesection or by section of the spinal cord. These experimental observations are in full accord with the well-known clinical fact that an aortic bruit is sometimes temporarily much less pronounced than usual, and may even occasionally disappear. An interesting paper has just been published by Professor Carl Dehio, of Dorpat (*St. Petersburg Med. Woch.*), in which he gives the details of a case which illustrates this variability of some aortic bruits very well. The patient was a student who had suffered

from syphilis. At times he experienced severe pain in the region of the heart, accompanied by dyspnea, headache, giddiness, and faintness. He had consulted several physicians, some of whom had detected a murmur, while others had declared there was none. Professor Dehio found at first, while the patient was sitting, merely some accentuation of the second sound, but as soon as he stood up a blowing murmur was audible over the whole of the body of the sternum synchronous with the second sound, and prolonged to the end of the diastole. After a time this became less and less perceptible, and finally vanished, but on the patient moving or working his arms about it reappeared. Tracings taken with a Dudgeon's sphygmograph showed that while the patient was in a recumbent posture, there being no murmur, the pulse, which was beating eighty per minute, was of a normal but weak character, with a slight distension wave and a low blood pressure, the secondary waves being only just perceptible. On standing up, the beats increased to eighty-eight per minute, the bruit becoming then audible, the tracing assumed the character frequently observed in cases of neurotic cardiac palpitation, the pulse wave being higher, but falling rapidly, and the secondary and tertiary waves being well marked. After considerable exertion, when the bruit was louder still, the beats being, however, only seventy-six per minute, the distension wave was three times as high as when the patient was lying down, and it fell very quickly, being in fact the typical *pulsus celer*. It is seen that the bruit was dependent on the initial blood pressure due to the force of the contraction of the left ventricle, rather than on the mean intra-arterial pressure, which was probably not increased, since, according to the researches of Reigel and of Wetzel, there is no increase in the mean pressure where the secondary waves become more pronounced. It is evident from the tracings that whenever the primary wave increased the secondary waves increased also, and thus, that while, when the patient was in a recumbent posture, there was but a gentle backward stream through the defective valves, yet upon a slight amount of exertion the velocity of this stream was greatly increased, and thus became capable of producing a murmur. This difference between a gentle and a rapid stream can be easily illustrated by compressing an india-rubber tube through which water from a cistern is flowing, when the murmur, which can both be heard and felt, is readily found to depend on the velocity of the water. Dr. Dehio remarks that he can not well have mistaken a murmur of hemic origin for a slight aortic insufficiency

in this case, for the whole history, the dilatation of the heart, the occasional whistling character of the murmur, and the serious subjective sensations of pain and palpitation all point to organic mischief. Again, the insufficiency must, he thinks, be of slight extent, as the dilatation of the left ventricle was but very moderate, and as Duroziez's double bruit was not audible in the femoral arteries.—*London Lancet*.

NECROSIS AND GANGRENE PRODUCED BY CARBOLIC ACID.—Dr. Max Kortium, of the Schwerin Town Hospital, writing in the *Internationale Klinische Rundschau*, mentions several cases which he has seen, and several more which have been reported to him by medical friends, where carbolic-acid applications have been followed by necrosis of bone or sloughing of the soft parts. In some cases there was no doubt that the patient had used much stronger lotions than were prescribed: in others it was possible that where patients or their friends mixed the solution they did not do it properly, and so some of the acid may not have been dissolved at all, and may thus have come in contact with the skin in an undiluted state. In all the cases referred to, the part affected was either a finger or a toe, and there had been a watery solution of carbolic acid applied continuously for from three hours to five days. There was always great difficulty experienced in getting the wounds left by the necrotic action of the acid to heal. Dr. Kortium quotes from Dr. Neill's paper in the *Edinburgh Medical Journal* for 1886, showing the action of carbolic acid on the sensory nerves. He points out that Dr. Neill has recommended glycerine solutions, finding that glycerine tended to prevent the ill effects of carbolic acid; also, that all his experiments were made on the trunk or on parts of the body much larger than fingers and toes. In the case of these latter organs, Dr. Kortium suggests that, when surrounded by lint soaked in a watery solution of carbolic acid, the latter, owing to its great power of penetration, enters into the finger or toe from all sides at once, and therefore is able to act very energetically on the nerves. Every surgeon is acquainted with the action of carbolic lotions on the sensory nerves—irritant at first and subsequently benumbing. If a similar effect is produced on the vaso-motor and trophic nerves, it is not difficult to understand that continuous action may cause a stoppage of the circulation, and thus set up necrosis or gangrene to a

greater or less extent. Again, it is possible that the carbolic acid acts also in virtue of its capacity of coagulating albumen. Of course these evil effects of carbolized applications are only occasionally observed. This is probably due to the fact that some persons have a peculiar idiosyncrasy for this drug. It is remarkable that almost all the cases which have come under Dr. Kortum's notice have occurred in females. The conclusion he arrives at is, that, when dealing with wounds of fingers and toes, watery applications of carbolic acid are best avoided. This, of course, does not apply to lotions used for syringing or washing the wound, but only to applications that are to remain for some hours or days. For this purpose creolin or corrosive-sublimate lotions are to be preferred.—*Ibid.*

DIAGNOSTIC VALUE OF "BALLOONING OF THE RECTUM" IN CASES OF STRICTURE OF THE BOWEL.—In the summer of 1886, while acting as *locum tenens*, I was called to see an aged lady who was suffering from constipation. There was a history of habitual constipation and painful defecation over a considerable period. With the help, however, of cascara as a daily medicine and enemata at intervals, the bowels had been kept fairly regular. On the occasion of my visit she was in great distress. There was an intense desire to pass something, and at the same time an utter inability to do so. This desire was so persistent, and she was so convinced of something being there, that I examined the rectum. The sphincter was firmly contracted, and, on passing the finger through, the condition that Mr. Bryant describes as "ballooning of the rectum" was found. There was a cavity in which the finger could be moved freely without coming in contact with the mucous membrane of the rectum. Nothing else was made out but this "ballooning," which existed higher than the finger could reach. An enema was ordered, and the patient was told that no substance could be felt, but if there was anything higher up the enema would very likely bring it away. About three hours afterward, there being no alleviation of the symptoms, a second examination was made. The same "ballooning" was found, and in addition there was felt projecting into the center of the cavity a pointed, hardened mass of feces. This was removed by copiously syringing the rectum and by manipulation. Some hours afterward other hardened masses, of the small size, came away naturally. The

subsequent history of the case I am not acquainted with; but I learned from the medical gentleman for whom I had acted that this state of matters had threatened before, but was warded off without having had recourse to treatment, which would have revealed the condition of the rectum. With reference to Mr. Bryant's statement that the "ballooning" is caused by retained flatus, I may mention that in the case referred to I used a speculum while syringing out the rectum, and on subsequent examination the same "ballooning" was observed, and at this time the hardened mass could only just be reached by the finger.—*D. Durran, M. B., Ibid.*

EXPERIMENTAL IODOFORM POISONING.—Dr. A. V. Koriander, of St. Petersburg, has endeavored to throw some light on the vexed question of the suitability of iodoform for use as an antiseptic by poisoning dogs with it, and examining the morbid appearances *post-mortem*. The iodoform is introduced into the peritoneal cavity in quantities varying from 0.3 to 1.5 gram per kilogram of the animal's weight. The microscopic sections of the organs were stained by hemotoxylin and lithion carmine. Nephritis affecting the renal glomeruli was invariably found, and the liver was infiltrated by minute fat granules. These appearances are considered by Dr. Philipovich to be characteristic of iodoform poisoning.—*Ibid.*

IS INSTRUMENTAL DELIVERY A CAUSE OF IDIOCY?—I find, from an examination of all my cases of idiocy about which positive information could be obtained, that in only three per cent were the forceps employed. In every case, however, where they had been employed, the friends of the child believed that the instrument alone was the cause of the disaster, while in nearly every case I could discover quite sufficient to account for the mental defect in the neurotic history of the progenitors. In a very few cases, only a small fractional percentage, could I arrive at the conclusion that the use of the forceps was the principal cause of the calamity. I find in a very large number of my cases that the labor was stated to be unusually tedious and prolonged. Dr. Playfair has shown that the employment of the forceps does not interfere with the viability of offspring; and that a prolonged labor is more compromising to the life prospects of the child than a judicious and timely application of the for-

ceps. "When it is borne in mind how frequent is the association of suspended animation with idiocy, it can not, I think, be too strongly enforced that the mental integrity of the child is more likely to be compromised by a prolonged pressure in the maternal passages than by skilled employment of artificial assistance. The accoucheur who postpones instrumental help often does so at the risk of terrible consequences to the nervous system of the little one he is solicitous to protect"—*J. Langdon Down, Ibid.*

**THREE CASES OF PURPURA RHEUMATICA.**—Miss M., aged twenty-two, Miss Y., aged thirty-eight, and Mrs. W., aged sixty. All three commenced with a severe attack of acute rheumatism, and were placed under the salicylic treatment for about ten days, when, the fever and pain having subsided, a mixture of bicarbonate of potash and cinchona was substituted. About the eighteenth day, large red spots, ranging from half an inch to an inch in diameter, appeared on the tibial and ulnar surfaces. There was considerable gastric disturbance, vomiting, and constipation, with some little diarrhea, and an average temperature of 102° F. I ordered an effervescing mixture and large doses of Hunyadi Janos water each morning; a generous diet, with lime juice and soda water to allay thirst, which in the case of Miss Y. was excessive. The spots were dusted with flour and covered with cotton wool, but in Miss M.'s case lead lotion had to be substituted, the heat and pain were so great. As soon as the gastric disturbance was allayed I gave them iron tonics.

All three have recovered, and are now free from rheumatism, with hearts unaffected; in fact, Miss Y. returned from Bournemouth about a month ago, saying she never felt better in her life, which I attribute to the course of hot sea-water baths she has undergone.

As I have never seen any cases like these before in practice, I should very much like to see the pathology of this peculiar disease worked out.—*Vincent J. Magrane, British Med. Journal.*

**LEEDS AND WEST-RIDING MEDICO-CHIRURGICAL SOCIETY.**—At the meeting on the 7th ult., Dr. Spottiswoode Cameron, President, in the chair, a paper was read on the Pathological Affinities of Lead and Alcohol, by Mr. Norman Porritt, who ascribed the prevalence of lead poisoning in Huddersfield to the character of the water-supply. He

then compared the actions of lead and alcoholism, dividing their actions for convenience into two groups, an excretory and a nervous group. The action of lead and alcohol is essentially paralytic, and there is not only nervous and muscular paralysis but metabolic and excretory paralysis. Alluding to the elective action of alcohol and lead, he thought that alcoholic consumption would explain elective action in a certain number of cases, and we ought not to be content with ascribing to elective action all cases of lead poisoning. Mr. Porritt concluded by giving an analysis of twenty-two cases of plumbism, fourteen males and eight females. Of the latter, only those over sixty years of age had severe or serious symptoms. Of the males, five only had gross nervous systems, and in all these there was history of indulgence in beer.—*London Lancet.*

**MALE STERILITY AND GYNECOLOGY.**—Dr. Fürbringer, of Berlin, has written some important observations on this subject in the *Deutsche Med. Wochenschrift*, No. 28, 1888. He believes that sterility in the male is far more frequently the cause of barren marriages than is generally believed to be the case. Aspermatismus is associated with complete impotence, but azoöpermia, or absence of spermatozoa in the semen—a condition by no means rare—may exist with perfect potency, and on that account is very easily overlooked. With few exceptions, azoöpermia is caused by obliteration of part of the seminal ducts. This condition is generally caused by double gonorrheal epididymitis, or inflammation of the vas. After that malady the chances are, Dr. Fürbringer has calculated, nine to one that azoöpermia will follow. Prognosis appears to be hopeless when the condition in question is not discovered till three or four months after the onset of the local inflammation. The chief importance of the management of the case lies in accurate diagnosis. True aspermatism is traced by Dr. Fürbringer to arrested development of the ejaculatory ducts. He declares that in several cases of sterile marriages under his own observation the unfortunate wife had been sent from physician to physician, or from hospital to hospital, and her cervix divided or her endometrium scraped, until a glance at the microscope proved that nothing was wanting to insure the blessing of children excepting spermatozoa. Dr. Fürbringer's observations are worthy of consideration. No doubt the increase of temperance involves the relatively

greater frequency of those forms of gonorrhea where the earlier symptoms are very mild. Hence the first stages may now be as much neglected by patients as they have ever been wont to neglect later stages. The more a case of gonorrhea is neglected, the greater will be the chance of serious secondary complications.—*British Med. Jour.*

#### ECZEMA PARTLY CURED BY VACCINATION.—

In November, 1884, a child was brought under my care with eczema. The child was covered with it from head to foot. It was the very worst case I had ever seen. I treated the child in the usual way for about six months, but with no benefit. I then advised vaccination. This the parents refused, saying that the vaccination officer had repeatedly postponed the vaccination. From this time I lost sight of the child for about two years, when the mother again brought her to me. I found the child in the same state, one mass of eczema. During the two years it had been attending at the Northampton Infirmary as an outpatient. I again advised vaccination, and this time the mother consented, remarking, what was very true, "that the child could not be made worse."

I procured some calf lymph and vaccinated in the usual way in four places. At the end of a fortnight there was a slight improvement, and now (three months after) there is a decided and marked improvement. The face is quite clear, and the body generally, except some patches on the head, the back, and the backs of the knees. After the vaccination I told the mother to keep the child as clean as possible, but no treatment of any kind was used. There was no history of syphilis in the case, and I believe the mother carried out as faithfully as she could the various methods of treatment prescribed for the child.

*Remarks.* I do not mean to say that vaccination is a cure for eczema, but I consider in a case of inveterate eczema it is worth a trial. In this case it was certainly a success, after every kind of treatment had failed.—*J. Howell Thomas, Ibid.*

**PYLORECTOMY.**—A successful case of excision of the pylorus is recorded by Drs. E. Goldenhorn and S. Kolatschewsky, of Odessa. (*Berl. Klin. Woch.*, No. 51.) The patient was a lad fifteen years of age, who was admitted under Dr. Goldenhorn for extreme dilatation of the stomach following an attack of pain and vomiting eight years previously. The diagnosis was simple stricture of the pylorus, an unusual event in so

young a subject; and after due preparation Dr. Kolatschewsky performed the operation of excision. The patient made a good recovery, slightly prolonged by the formation of an abscess at the seat of suture. The portion of the stomach removed included 2.5 centimeters of the lesser, and 4.5 centimeters of the greater curvature; the mucous membrane was thickened and thrown into folds, which at the pylorus itself formed polypoid masses, completely blocking the orifice. This condition doubtless resulted from the cicatrization of an ulcer seated at the pylorus, and not from any congenital defect.—*London Lancet.*

**SULPHONAL.**—The new hypnotic, sulphonal, has not, as far as I am able to ascertain, been much used on insane patients in America. In the *La Riforma Medica*, Dr. Algeri has reported the use of the drug with the happiest results. His experiments embraced sixty trials on fifteen cases. The good results reported from sulphonal as a hypnotic in cases of insomnia from worry, fatigue, etc., together with the report of Dr. Algeri, have led me to make a further trial of it in the insomnia of the insane, the results of three cases of which will be seen below, together with the report of four hospital cases.

Until quite recently there were two preparations of sulphonal in the market, one by Bayer and another by Riedel. Quite recently, however, an injunction was granted restraining the manufacturers of Riedel's preparation from furnishing any more of it, as there was a patent on the article by Bayer.

Of the value of Bayer's preparation I know nothing, as my experiments have been conducted entirely with Riedel's preparation.

As the drug is sparingly soluble I have given the powder dry on the tongue, and had it washed down with water. For a draught the Chemist and Druggist recommends the following:

Sulphonal.....	grs. xxx;
Syrup .....	} .āā f3ij;
Mucilage of acacia }	
Distilled water.....	f3 j.

Dr. Lovegrove recommends compound tragacanth powder to suspend it, but the viscosity is objected to. The size of the dose renders it objectionable for administration in pill form. It has also been used in wafers, but as it is tasteless I think there is no better way than by administering the dry powder and washing it down with water

The advantages of sulphonal may be summed up as follows:

1. It is perfectly tasteless, and is tolerated by the stomach.

2. It has no disagreeable after-effects in ordinary therapeutic doses.

3. It does not, as far as I have been able to judge, produce a habit, nor does it in my experience lose its effect if frequently administered.

One of the disadvantages of its use in hospital practice is the high price at which it is sold; but there is no doubt that in course of time the price of sulphonal will be somewhat reduced. At present the price is about twenty cents per dose.—*E. B. Landis, M.D., University Med. Magazine.*

**PULMONARY ACTINOMYCOSIS.**—Dr. Matschinski relates, in *La Gazette Clinique Hebdomadaire de Botkin*, a curious case of this disease which he diagnosed during life. The patient was a man suffering from typhoid fever and croupous pneumonia, whose expectoration Dr. Matschinski was examining microscopically, when he found it contained the stellate and filiform fungus of actinomycosis. The filaments of the fungus were of an extreme fineness, dichotomous or rosaceous, from which slender thread-like processes were given off like the branches of a tree, but which were interlaced at the periphery. Fuchsin colored these filaments a dark red, the groundwork being colored blue with methylene blue. The necropsy confirmed the diagnosis made. At the base of the right lung was a cavity, as large as an orange, filled with pus, in which were found fungi of the same kind as appeared in the sputa. Dr. Matschinski suggests that Ehrlich's method would be more useful in making a differential diagnosis between actinomycosis and tuberculosis—two diseases which, he thinks, might easily be confounded.—*London Lancet.*

**ANTISEPTIC BANDAGES.**—The inefficacy of bandages, etc., prepared with sublimate alone has led Dr. Laplace to examine into the causes which produce this condition of things. He has determined that the chief reason is the formation of insoluble albuminate of mercury by decomposition of the bichloride in contact with the cloths and materials used in their preparation. This may be avoided, as he has demonstrated, by the presence of an acid in the sublimate solutions used for asepticizing the bandages, gauze, etc., and of all the acids with which he experimented, tartaric acid seems to be

the best. When this acid is added to sublimate solutions, not only is the formation of albuminates avoided, but the antiseptic effects are increased in a remarkable manner, thus enabling a smaller percentage of sublimate to be employed; and, moreover, so fully answering all demands that the collateral use of iodoform, etc., is rendered entirely unnecessary. The acid solution is also less irritating to wounds. The following are Laplace's formulæ, as gleaned from *La Gazette Degli Ospitali*: Take of bichloride of mercury, one part; tartaric acid, five parts; distilled water, one thousand parts.

This solution is for irrigations, etc.; but when antiseptic bandages, gauzes, etc., are to be prepared, the following is recommended: Take of bichloride of mercury, five parts; tartaric acid, twenty parts; distilled water, one thousand parts. Mix.

The material should be submerged in the fluid and left there for at least two hours. We would suggest that the softness and suppleness of the bandages, etc., would be very much increased by the addition of a small amount of glycerine, say one part to each hundred parts of water.—*National Druggist.*

**ETHERIZATION; AN UNRECORDED DANGER.** It is not uncommon to read, at the end of the description of some prolonged operation, a statement to the effect that when the patient was put back into bed it was found necessary to use several hot-water bottles to restore heat to the chilled surface. The fall of temperature which has impelled surgeons so constantly to resort to this expedient has been generally attributed to the combined effects of exposure and shock. Dr. H. H. Hare, of the University of Pennsylvania, has pointed out (*Ther. Gaz.*, May, 1888) that another factor must be taken into account. Observation on patients in the University Hospital showed that the difference in the rectal temperature before and after operation might amount to as much as three degrees, and a comparison of the effects observed after various operations appears to prove that the whole of the effect could not be attributed to shock and exposure, but that a large, possibly the greater, part was due to ether, which was the anesthetic used. This view found confirmation in the result of some experiments on dogs: By continuous etherization for an hour, giving five drams of ether every five minutes, after the animal had been brought thoroughly under the anesthetic influence, the normal rectal temperature of the dog was reduced as much as from 8° to 10° F. Dr. Hare's inquiry suggests that it would

sometimes be well for surgeons to combat this antipyretic action of ether by warm applications during the time that the patient is on the operating-table. — *British Medical Journal*.

**ANTIPIRYN IN THE PAINS OF LABOR.**—Auvard and Lefebvre have been unable to convince themselves of the far-famed action of antipyrin in the pains of labor. They tried it in ten cases in the maternity of the Paris Charité. Only three patients showed the effects of antipyrin; of these a marked relief was produced in one, and a slight relief in two cases; in seven the effect was *nil*. The solution used by them is as follows:

Antipyrin.....gr. cviii;  
Muriate of cocaine.....gr. iss;  
Distilled water .....f 3 v.

A syringeful, containing four and one half grains of antipyrin, was injected three or four times.

In reviewing this experience a writer in the *Wiener Med. Presse*, November 11, 1888, remarks that in a case of his own fifteen and one half grains of antipyrin internally, and the same amount hypodermically, had not the slightest influence upon the intensity of the labor pains. — *Medical and Surgical Reporter*.

**EXPERIMENTS WITH CREOLIN.**—Michael Pleskoff communicates to the *Therapeutische Monatshefte* some therapeutic experiments with creolin, which he made in the wards of of Prof. Jurasz, in Heidelberg, in cases of chronic rhinitis, ozena, and dry pharyngitis. He made use exclusively of a one-per-cent watery solution of creolin, and employed it in fifteen cases. The results obtained were so favorable that the author most warmly commends it for further trial. In chronic rhinitis with or without fetor, tampons of cotton were dipped in the creolin solution, very gently squeezed out, and introduced deep into each nasal chamber by means of a sound. The tampons were allowed to remain about twenty minutes. During this time the patients felt a slight burning, which, however, soon passed away upon removal of the tampon. Unpleasant symptoms were never observed. The favorable effect of the creolin showed itself in a comparatively short time by the qualitative and quantitative change in the secretion. The quantity of the discharge diminished and its purulent character gave place to a more normal secretion of mucus. It exercised an especially good influence upon the troubles present in

ozena. It caused the disappearance of fetor more quickly and completely than had been effected with carbolic acid. Formation of crusts also ceased, and the secretion of the mucous membrane became normal. The results were not less favorable in the so-called dry pharyngitis, in which affection the tampons were pushed through the nose to the nasal fossæ, so that, by hanging down, they came in contact with the mucous membrane of the pharynx. The rest of the mucous membrane of the pharynx was swabbed with a pledget of cotton wet with creolin solution, and held in place with forceps. *Ibid*.

**CAPILLARY ASPIRATION OF THE BLADDER.** This was one of the subjects brought before the Society of Naturalists, at Cologne, by Drs. Rosenberger, of Würzburg, and English, of Vienna. The first speaker remarked it was a procedure warmly recommended by Lücke, and he wondered that it was so little practiced. The operation was easily performed. Any kind of aspiration could be used, and a fine needle no thicker than an ordinary knitting-needle passed into the bladder above the symphysis in the linea alba. When all the fluid was evacuated the canula should be removed with a sudden jerk. By this means no bleeding took place, especially if care was taken to keep the sides of the canal together until they adhered. Of course all antiseptic precautions should be made use of. In old people it was sometimes necessary and frequently useful. It often happens that when aspiration had been performed two or three times the patient could micturate naturally, or a catheter could be introduced, when before such a thing was impossible. It was a procedure generally indicated in retention of a passing character, and when catheterization set up violent hemorrhage from the urethra. The pain from the operation was slight, frequently less than was caused by introduction of a catheter. Dr. English, of Vienna, said he had never practiced capillary aspiration of the bladder, and criticised the procedure adversely as both unnecessary and dangerous. — *Medical Press and Circular*.

**ICTERUS NEONATORUM.**—Professor Neumann, of Königsberg (*Virch. Arch.*, cxiv. 3), in endeavoring to throw light upon the vexed question of the true nature of icterus neonatorum, whether it is hematogenous or hepatogenous, has availed himself of the fact that in fatal cases of jaundice free crystals and granules of bilirubin are to be found in the various tissues, especially in the fat cells.

of the omentum and elsewhere. Some years ago he detected such precipitates in the case of an infant, who died from congenital heart disease, four hours and a half after birth, without showing any sign of jaundice. He has during the past year examined the bodies of twelve still-born children, and in no fewer than eight found this precipitation of bilirubin—not indeed to the wide extent prevalent in *icterus neonatorum*, but limited to the fat cells of omentum and subserous fat in various parts of the body. He rejects the idea that its occurrence is due to decomposition of blood pigment, such as occurs in the dead fetus long retained *in utero*, since in no case examined was there any evidence of death having occurred long before delivery. He also excludes the possibility of *post-mortem* transudation of bile, since the tissues in which the bilirubin mostly occurred were remote from the gall-bladder and intestine. Indeed, he is forced to believe that the bile is already present in the blood, and that after death it crystallizes out in the fatty tissues. Hitherto, however, attempts to determine the presence of bile in the blood of the newborn have failed, but the experiments have been insufficient. The fact he has noted suggests that *icterus neonatorum* may be due to an exaggeration of certain processes natural to fetal life, and not dependent upon the circulatory changes taking place at birth. On this view it would be a true hematogenous *icterus*—*Lancet*.

**REMOVAL OF SUBPLANTAR CORNS.**—Unna (*Monatshefte für prakt. Dermatologie*) states that the treatment of subplantar corns is very much facilitated by a judicious combination of salicylic plaster and glycerine jelly. A ring of glycerine jelly, about the diameter of the wart, is painted round it with a fine but stiff bristle paint-brush. When this ring of jelly has quite set and become dry, a circular piece of the strongest salicylic-plaster muslin (salicylic acid and creosote, each forty parts) is cut sufficiently large to fit within the ring of jelly; jelly is now painted over the ring of jelly already made and the piece of plaster itself; and, to make assurance doubly sure, a third coat of jelly should be painted widely over all; and when these have become almost dry, a layer of cotton wool is to be placed and pressed on. The larger the surface covered with the jelly the less the local pressure on the corn. In the case of feet which perspire much, especially in hot weather, a single turn of a soft muslin bandage should be folded round the affected part of the foot, before the jelly has become quite dry, covered with a

coating of jelly and then of wool, or a coating of jelly itself, and the neighboring part of the foot painted with flexible collodion. In this way one can keep the plaster in position, even in the heat of summer and in those whose feet sweat freely. The dressing is changed when it becomes spontaneously loose—at the oftenest, once or twice a week; the horny layer acted on by the salicylic acid is removed, and a new dressing applied; and this had better be continued for some time after the wart has been cured.—*Edinburgh Medical Journal*.

**QUININE POISONING, OR ICTERO-HEMATURIC FEVER.**—Professor Tomaselli, of Catania, Italy, at the meeting of the Italian Society of Internal Medicine, read a paper upon Quinine Poisoning, stating that during the last year he had seen many cases in which quinine had been administered without producing any marked effects upon the malarial condition, but on the contrary produces an outward effect, the prominent symptoms being fever and hematuria.

From one to six hours after the quinine has been taken the patient has a severe chill, with fever  $106.7^{\circ}$  to  $108.5^{\circ}$ , followed by vomiting and diarrhea and great desire to urinate, and later by the passage of bloody urine. These symptoms last twenty-four hours, terminating by a fall of temperature. Jaundice sometimes occurs, and it may remain a week or so. If the quinine is not stopped, these paroxysms will continue, and the patient fall into collapse and die.

The next prominent changes occur in the blood, the red corpuscles becoming discolored and reduced in number, and hemoglobin is found in the urine, as are also the bile pigments, epithelial cells, and fibrinous casts. Considerable discussion was the outcome of the reading of this paper, and most of the learned doctors were disposed to take issue as to the quinine causing the condition which the professor called quinine poisoning or ictero-hematuric fever.—*St. Joseph Medical Herald*.

**CREOSOTE IN PHTHISIS PULMONALIS.**—Dr. Austin Flint, in the *New York Medical Journal*, reports ten cases of phthisis pulmonalis in which marked benefit was derived from the inhalation of equal parts of creosote, alcohol, and spirits of chloroform, ten or fifteen drops being put on the inhaler four or five times a day, or even more frequently.

Creosote was also administered internally, and in some cases cough mixtures, tonics, and the like were also given. In eight of the cases tubercle bacilli had been discovered. The result of the treatment was very gratifying, the appetite, strength, and general condition showing in every case marked improvement.

# The American Practitioner and News

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H. A. COTTELL, M. D., } - - - Editors.

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## INHERITANCE OF ACQUIRED TRAITS.

We hear a great deal of the inheritance of acquired traits of character, and it can hardly be doubted that there is a popular predilection in that direction that facts scarcely justify.

The aspect in which such inheritance is supposed most commonly to manifest itself is in fondness or weakness for intoxicants. The popular notion in this respect, as in nearly every other, seems to us to have been reached through a too superficial survey. We will venture to say, that instead of a tendency to inebriety being increased among a people by excessive indulgence, it can be shown that the opposite is true, and that the weak rather perish and are eradicated.

It will, it is true, hardly be disputed that any very exhaustive tax on the vital forces of parents impairs the powers of the offspring, and that such offspring are weak before all trials. How often it happens that stingy, penurious parents, who have exhausted their vital forces on the accumulation of fortune, leave descendants whose avarice overbalances their industry and leads them to become thieves. In the use of intoxicants we have only to consider the almost universal and overpowering disposition of savages to excessive indulgence.

Among these, for untold centuries, not a taste of alcohol may have been had, yet the moment it is introduced a whole tribe is ready to become besotted.

In cases of supposed inheritance of acquired taste for intoxicants among civilized people, it is likely that the son drinks, in a large proportion of cases, because he inherits the same weakness that led the father to excess.

## PROF. JOHN C. DALTON.

Prof. Dalton died in New York, February 12, 1889. He was born in Massachusetts in 1825. He graduated from Harvard University in 1847. He filled the professorial chair successively in the medical department of the universities of Buffalo and Vermont, Long Island Hospital Medical College, and the College of Physicians and Surgeons of New York, being called to the chair of physiology in the latter in 1855. From this date till the day of his death, with the exception of a term of service in the army, where he became brigade surgeon, he has been connected with this institution as professor or chief executive officer.

Dr. Dalton was a profound scholar, a great teacher, a writer of grace and power, a pioneer in demonstrative biological science, and a gentleman of fine culture and rare beauty of character.

His classic works on Human Physiology, the Anatomy of the Brain, and the Doctrines of the Circulation of the Blood, are an honor to American medicine.

## THE MEDICAL PRACTICE ACT.

Though there remains but one month in which to comply with the law, but a little over fifty physicians in Louisville and Jefferson County have complied with the act relating to medical practice, passed by the last legislature. This is but about one in six, as there are doubtless more than three hundred physicians in the territory named.

Up to this date about six hundred diplomas from colleges outside of the State have been indorsed by Dr. McCormack, Secretary of the

State Board of Health. As the law will certainly be enforced, even if for no other reason, all qualified physicians should register, and escape the penalty of its violation. But a stronger reason still is the moral support given by prompt compliance. If a large number of qualified practitioners show their indifference by failure to comply, and are caught with the quacks and frauds in the penalty, the moral effect of violation is in a large measure mitigated to the latter class.

Steps have been taken by the Louisville Medical Society to employ additional counsel, if necessary, to assist in the effectual enforcement of the law. It is to be hoped that every qualified physician in the city will in good time register and be prepared to aid in the enforcement of the law, and thus sustain Dr. McCormack in the vigorous course he is ready to pursue.

### Notes and Queries.

DONDERS AND MOLESCHOTT ON PRE-PROFESSIONAL EDUCATION.—The great Dutch physiologist and ophthalmic surgeon, in reviewing his educational career, dwelt with gratitude on the classical studies he pursued under clerical auspices at Boxmeer. Certain it is that to that discipline he owed his skill in the use of language and his love for the elevated and refined in thought and expression, which never failed him in after life. Commenting on this avowal of Donders, his biographer, Moleschott, says that no one who is conscious of his own mental evolution can deny that such early educational influences infuse a love of study for its own sake—a habit of mind which is worth more than all the acquisitions one can make in the secondary schools. We must, he says, do justice to the old Latin (or, as we should say, grammar) school, and acknowledge that it was in no way inferior to the best and most comprehensive of the modern schools in cultivating an eagerness to learn, in awaking a passion for the search after truth, in evoking an admiration of the beautiful. Goethe, in the sixth book of his "*Wahrheit und Dichtung*," spoke prophetically when he said: "The injury done

to our youths by impelling them too exclusively in certain lines of instruction is most manifest when their training in the use of language is minimized and the value of their preparatory discipline impaired to devote the time and attention thus gained to the ensuring them to so-called 'real study,' which tend more to distract than to cultivate the mind, unless they are carried out with system and with thoroughness." Indorsing this argument, Moleschott adds: "The study of language and literature involves, according to some, a loss of the time which should be bestowed on physical science. But those who think so forget that, in early youth, its instructor must not have in view the exercise of the intellect alone; he must also, and primarily, educate the heart and the taste; he must feed the faculties by which we appreciate and admire the beautiful and the noble; he must kindle enthusiasm for virtue and patriotism; in a word, he must mold the sentiment of duty and the aspiration after the ideal. If, in the prosecution of such discipline, there is the sacrifice of some hours that might be employed on subjects more apparently useful, we have in compensation the development of that large and loving knowledge of man and of the world, the storing up of reflections which elevate the youth into the noble thinker, who, at a more advanced stage, grasps with ease the facts that are useful, and is preserved from the danger of becoming a mere referee of data or a poor proper after the light." Donders began his professional education, says Moleschott, without being initiated in what Goethe called "real studies," and has never regretted it.—*London Lancet*.

DEATHS OF EMINENT FOREIGN MEDICAL MEN.—The deaths of the following eminent foreign medical men are announced: Dr. Leopold Wittelshöfer, immediately after giving up the post of editor of the *Wiener Medizinischer Wochenschrift*. Dr. Johann Wagner, formerly Professor of Special Pathology and Therapeutics in Buda-Pesth, at the age of seventy-eight. Dr. Léon Damas, Professor of Midwifery at Montpellier. Señor Don Dr. Pedro Lletget y Diaz-Ropero, Professor of

Botanical Pharmacy in the University of Madrid, Member of the Royal Academy of Medicine and of the Sanitary Council. Dr. A. Bieltsoff, senior surgeon to the Marien Hospital, and *privat-docent* in Surgery in the Military Medical Academy, St. Petersburg.—*Ibid.*

REMEDIES IN SAVAGE LIFE.—A learned discussion has been carried on in Virchow's *Archiv* on the significance of repulsive rites in barbarous races. It involves the familiar question as to the significance of the fact that old-fashioned medicines are not only very compound, but also very nasty, while the tendency of the age is to make mixtures taste nice, and even a further step is forced upon pharmacy by the delicate ideas of the nineteenth century invalid. He dislikes any flavor in the drugs which he takes; even if the taste be otherwise nice, its association with physic makes it disagreeable. For that reason pharmacists endeavor to make their compounds tasteless, coating pills and capsules with protective envelopes which can not dissolve until they reach the stomach. On the other hand, the savage delights in making his potions as nasty as possible. A study of primitive abstract ideas shows that the swallowing of offensive substances is a common rite in the forms of devil worship which prevail among barbarians. The rite is performed both for supposed spiritual and temporal benefit and for the cure of sickness. From such rites is medicine evolved. Dr. Hampden Porter, in a paper written in English in Virchow's *Archiv*, writes: "Originally all medicines are essentially charms. No savage has any conception of the natural causation of disease. Illness and accident are unhesitatingly ascribed to the direct or indirect action of some supernatural agency, and are therefore supposed to require counteractives of a corresponding kind. Most of the afflictions of unevolved men are believed to be due either to sorcery or to the malice of one of his minor deities, nearly all of whom are evil spirits; and this because they are the offspring of fear, and everywhere fear is more powerfully suggestive to the fancy than gratitude or hope." As a race progresses above barbarism, rites become more and more refined,

and differentiation between drugs and sacrificial compounds takes place very early. Yet traces of the original significance of drugs are retained even in relatively high stages of civilization. Certain medieval medicines were made up of filthy materials.

The last relic of medicine as a propitiatory mortification is seen in the trust which a minority of civilized people still place in nasty preparations. Many Englishmen still think that a good dose of black draught, followed by a big blue pill, is the right treatment for most forms of gastric disturbance, and better than new-fangled elegant preparations. The nauseous character of such remedies is their chief recommendation. To take them gives the patient (his own doctor, as a rule) a flattering sense of wholesome self-inflicted mortification. The old Puritan spirit is not extinct; it always encouraged such notions. There remains the question of children's medicines. Old-fashioned parents think that the administration of nasty draughts to their offspring acts as a salutary form of discipline as well as a cure for juvenile ailments. There is some truth in this opinion. On the other hand, who can doubt that the dread of "black draught" or "rhubarb-and-mag." still causes thousands of children to conceal as far as possible all symptoms of minor ailments? It can not be doubted, however, that if physic be made nice a contrary evil will prevail. A very little child will cough so that it may get more syrup.—*Brit. Med. Jour.*

THE ANTISEPTIC TREATMENT OF GONORRHEA.—(By DuCastel, *L'Union Med.*, 1309, 1888.) The therapy of gonorrheal urethritis has two objects to accomplish, namely, the destruction of the gonococcus, and the cure of the inflammation of the mucous membrane. The first is generally accomplished by antiseptics, the latter by astringents and balsams.

The great benefit derived from the antiseptic treatment is its prevention of further propagation of the disease and avoidance of complications.

Carbolic acid, permanganate of potash and bichloride of mercury, the antiseptics usually employed, are objectionable in that

they irritate the mucous membrane. This objection does not apply to resorcin; the injection of this drug is as painless as if pure water was used; it does not cause the slightest inflammation. The writer claims to have had the same brilliant results with this drug as Letzel, namely, the cure of acute gonorrhea in twelve days, and chronic in from fourteen to twenty-two days.

He uses a two-and-one-half-per-cent to three-per-cent solution in acute cases, and a four-per-cent in chronic cases. Only a small quantity of the solution should be prepared at one time, and this should be kept in dark colored glass bottles and in a dark place. In this way only can the solution be kept pure.

In the last stages of the disease the writer uses balsams which, although not absolutely necessary, seem to shorten the duration of the disease.

ACCORDING to the *Progrès Médical*, Metzger, the famous *masseur* of Holland, puts himself out for no one. The Empress of Austria, the princes and princesses who have undergone his treatment, have been obliged to come to him. The Pope is the only person in whom he has made an exception by visiting at Rome. His charges are the same to all. He sees no one at his house; but his patients, who come from all corners of the world, meet twice a day at the Hotel Amstel, which owes its success to Metzger, and in turn spend several minutes with the doctor, who submits them to partial massage as they need it. This specialist, as a boy, was a butcher, and his observations on the lower animals and their muscles led him to this specialty. He studied medicine and received the degree of M. D.—*Maryland Medical Journal*.

THE LANCET announces that it has founded "The Lancet Medical Fund," the object of which is to afford immediate pecuniary assistance in emergencies to medical men, or, in case of the death of a medical man, to his widow or orphans or dependent relatives. The almoners of the fund are to be the President of the Royal College of Physicians, the President of the Royal College of Surgeons, the President of the General Medical Council, and the two

proprietors of the Lancet. The latter will generously place at the disposal of the almoners a sum of at least \$1,500 a year, which will be administered free of cost, and they do this to express their sense of the generous support which the profession has accorded to the Lancet during the sixty-six years of its publication.—*Medical News*.

MISS FLORENCE NIGHTINGALE has never recovered from the severe strain to which she was subjected in her noble work of nursing during the Crimean war. She is now an invalid from spinal disease, in her seventieth year, and is an inmate of St. Thomas' Hospital, where she will probably end her days, tenderly cared for by the nurses who in that excellent training school are reaping such benefit from the Nightingale fund of \$250,000, which was raised in 1858.—*New England Medical Monthly*.

DISAPPOINTED AMBITION.—The students of the Medical Department of the University of the City of New York are in a state of mutiny against the Faculty because their instructor in anatomy, Dr. Weisse, who is a great favorite with them, has not been raised to the Chair of Anatomy, which has just become vacant. They declare that one half of their number will leave the college unless justice be done to Dr. Weisse, who has been connected with the University for twenty-five years. The Faculty say that the vacant chair will be filled by competitive examination, at which Prof. Weisse may attend as an applicant if he desires.

S. WEIR MITCHELL, M. D., LL. D., has been elected Professor of Diseases of the Mind and Nervous System in the Philadelphia Polyclinic and College for Graduates in Medicine, an additional chair upon that subject being created.

KENTUCKY STATE MEDICAL SOCIETY.—The next meeting of the Society will be held on May 8th, 9th, 10th, at Richmond, Ky. Reduced rates at hotels and on railroads will be secured.

**NITRO-GLYCERINE IN HEART FAILURE.**—Dr. M. H. Firnelli, of Philadelphia, reports three cases of heart failure, where hypodermic injection of two drops of one-per-cent solution of glonoin (nitro-glycerine) was used, and says: "One who has seen cases of heart failure treated in the usual way can have no conception of the brilliant results which may be obtained from this agent."—*New England Medical Monthly*.

THE editor of the Journal of Cutaneous and Genito-urinary Diseases announces that, beginning with January number, the magazine will be published by D. Appleton & Co. No essential change will be made in the style or appearance of the Journal. All arrears should be sent to William Wood & Co., and all renewals and subscriptions for the new volume to D. Appleton & Co.

AN International Congress of Physiology will be held at Basle, September 10, 1889. The Congress, the idea of which originated with the English Physiological Society, will also embrace the subjects of anatomy, histology, physics, chemistry, experimental pathology, and pharmacology.

KEITH says that hysterectomy is an operation that has done more harm than good. One out of every four operations has been fatal. Cancer is the only disease for which the procedure is at all justifiable.

PROF. LIEBREICH announces, in the November number of the *Therapeutische Monatshefte*, that he has succeeded in producing cocaine by synthesis. Merck, of Darmstadt, claimed the same more than a year ago.

THE President of the Board of Health and the Health Officer of Jacksonville, Florida, have issued bulletins declaring the city of Jacksonville and the county of Duval free from yellow fever and perfectly safe to visit.

AN Intercolonial Medical Congress is to be held at Melbourne in 1889.

THE Royal College of Surgeons of England has passed a vote of censure on Sir Morell Mackenzie for publishing his book on the case of the late Emperor Frederick. The vote was twenty-one to two.

HEMORRHAGIC, or "black" smallpox is stated to prevail in Adrianople; and sanitary cordons, with medical inspection, have in consequence been imposed on the Villayet by the Bulgarian Government.

COCAINE and oleaginous substances, when combined, cause a great deal of pain, says the North Carolina Medical Journal.

THE relations between alcohol and renal diseases is the subject of a debate to be held before the Pathological Society of London on December 4th and 18th.

SEVERAL families in Albany, N. Y., are reported to have been poisoned by eating cheese and pickles. No deaths have occurred.

IN diabetes diluted phosphoric acid quiets the inordinate thirst more effectually than any other drink.

DR. A. L. LOOMIS has been elected President of the New York Academy of Medicine.

DR. FRANK P. FOSTER, editor of the New York Medical Journal, is convalescing from his recent severe and critical illness.

### SPECIAL NOTICE.

**OBSTINATE CONSTIPATION.**—E. A. Scott, M. D., Columbus, Kansas, says: I have a patient, a man who has been constipated four years, has called upon all the physicians in the place, none had benefited him, never having an action upon the bowels oftener than six to eight days. He is now taking the Acid Mannate, small doses daily, keeping his bowels free. I have a lady patient who is suffering with a uterine trouble and has periodical nervous sick-headache (I think solely dependent upon the uterine trouble); she is also constipated. I have her upon the Acid Mannate; she, as well as myself, is pleased with its effect; her headaches are not so frequent or severe.

# THE AMERICAN PRACTITIONER AND NEWS

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[NEW SERIES.]

*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.*

## Original Articles.

### NATURE AS PHYSICIAN AND SURGEON.

The Doctorate Address in the Medical Department  
of the University of Louisville, 1889.

BY TURNER ANDERSON, M. D.

*Professor of Obstetrics and Diseases of Women and Children in  
the University.*

An eminent French surgeon, obstetrician, and writer, whose life was spent in active intellectual effort, and whose last words were "One must work always," said: "Nature is a good physician but a poor surgeon." Such a sentiment coming from so great a man is entitled to the weightiest consideration; but, like all epigrammatic and seemingly axiomatic declarations, is a subject for legitimate criticism, because, if literally accepted, it may sway or bias medical opinion and practice in opposition to truth based upon facts. I therefore invite your attention to a few thoughts suggested by this sentiment, and will endeavor to prove that nature is not a better physician than surgeon; but that, in a limited sphere and under such regulations as the advances of science have discovered, her help is essential to the success of both. It is much easier to see how nature bungles in her efforts to restore a broken limb or to correct a rapidly increasing deformity, than to judge of what she does to cause a restoration to health of a concealed morbid process. In the former case her subjects generally make some sort of recovery, and stand forth as living monuments of what she can not and

does not accomplish without the aid of art. In the latter her subjects either recover and live to glorify her skill, or die, burying out of sight her shortcomings and her failures. Why, then, this seeming disparity between the results of medical and surgical practice? Is it because surgery does not trust to nature, and that medicine trusts her too far? While it is clear that neither medicine nor surgery can get on without nature's help, it may be easily shown that the more brilliant results obtained through surgery are due to the fact that greater care is taken to insure these results. For well does the surgeon know that his blunders are to confront him and advertise his want of skill—hence the nicety of surgical technique, the scrupulous care with which operations are done; with which dressings are applied to injured parts; the selection and preparation of instruments for the meeting of any emergency; antiseptic precautions, and the general painstaking supervision which is exercised over all procedures connected with the art—for experience has long shown how neglect of these things must bring disaster and failure. This being the great price of success, the surgeon pays it most cheerfully, for he well knows that if his results do not come up to or surpass what the modern improved methods render certain, he is sure to suffer in reputation and lose his patients.

You have seen how carefully the technique of surgical practice is carried out in all operations at the University clinics, and you have witnessed the brilliant results which have followed. The abdomen is opened and large tumors removed, joints excised and deformities corrected under modern methods, which in days gone by would either have not been attempted, or, if done, would

have been attended with a disastrously high rate of mortality. Now I mention these things, not for the purpose of praising our methods, for this is unnecessary—you are familiar with them, and will soon have opportunity for verifying the wisdom of what you have been taught—but for the purpose of drawing a contrast between these methods and what I regard as a great fault in the present mode of applying therapeutic principles, or what might be called the technique of medical practice.

The application of medicine in the treatment of disease is not based upon the idea that disease is an entity to be physicked out of the body; but, contrary to popular belief, its exhibition is based upon what is recognized as the physiological action of the remedy employed, and the alterations in the economy which the disease produces.

Let us take as a familiar illustration the medical treatment of an inflamed joint or internal organ. In this case the acuteness of the pain is in direct ratio to the acuteness of the inflammation. The increased afflux of blood to the inflamed organ produces increased tissue change, and if not controlled will run so high that destruction of the part will result. Now, a study of the physiological action of drugs has placed in our hands agents which relieve pain. One of these is selected and given, and as a result pain ceases, irritation is allayed, the disease controlled, and its disastrous results forestalled. Here we have an effect as plainly demonstrable as any attained by surgery in cases like or analogous. Nature's efforts would have been incompetent to restore the diseased organ to health without the aid of medicine, as they would have been in a similar case without the help of surgery, and in either case would have left it in a permanently damaged condition.

There are many diseases in the relief of which nature displays no marked power, and this fact is not in opposition to what might be expected when we consider how unnatural disease is. The illustrious Boerhaave said that the only disease natural to man was old age. The statistics of nature's

cures makes no mention of this disease. In truth nobody dies of old age. Not a few attain to the psalmist's utmost allotment of years; but they always die of morbid processes as clearly demonstrable as any of the affections of the young or middle-aged—in other words, of diseases due to natural causes. Here we have nature, our good physician, furnishing the cause, and killing instead of curing her patients.

Let us inquire what nature does for one of the most common of all diseases, namely, rheumatism. The chronic form of this affection never gets well without medicine. The acute form often becomes chronic if left to nature, is never recovered from in less time than six weeks, and then after great suffering. In contrast to this how different are the results now obtained from recent therapeutic measures, chiefly drugs. To-day acute rheumatism is cured, pleasantly and safely, in from thirty-six to forty-eight hours, under the exhibition of medicines. Can nature or surgery boast of results more brilliant? These results are certainly in striking contrast with those obtained under the old methods of treatment which practically left the disease to the tender mercies of nature. The advances in therapeutics have been so rapid in the past quarter of a century that the physician can cure not only rheumatism, but numerous other diseases, as certainly by the use of medicines as the surgeon can manage successfully many diseases, fractures, dislocations, and deformities by the appliances of his art.

A striking illustration of the power of drugs to cure a disease long considered amenable only to surgery, is to be found in the recent treatment of glaucoma. Eserine does to-day what was formerly done by the knife.

Illustrations similar to the above might be indefinitely multiplied, wherein nature has proved so poor a physician as to be unworthy of trust, and in which medicine guided by a knowledge of its action upon the healthy organism and the diseased processes which it is given to counteract, accomplishes results even more striking. These

results are obtained only by those who have the knowledge requisite to make scientific application of therapeutic agents and principles, and who apply that knowledge in a most painstaking and systematic way, giving attention to all the essential details of medical practice. A want of this knowledge, or thoughtlessness or carelessness in the application of it, is the glaring fault of the times.

Nature is indeed a better doctor than he who believes he has done all that he is called upon to do when he has written a prescription for the drug to be used by his patient. The every-day experience of doctors confirms the assertion that few persons have sufficient information to intelligently administer the commonest medicines in a proper way. Their general knowledge and culture may make their companionship desirable, and perhaps they may be able to instruct the doctor upon many topics of which he has no information, but when it comes to a knowledge of what is expected from the action of medicine, they are not to be trusted. In illustration of this truth many humorous instances of how patients take our medicines might be cited; but when, in consequence, we fail to obtain the expected results, and we feel our reputation likely thereby to suffer, they cease to be funny and tempt us to express our disgust in language more emphatic than elegant.

Chemistry, by extracting the active principles of many potent drugs, places in the hands of the physician agents in such a state of concentration as to require great care in their exhibition, and to render dosage a question of much nicety. Their administration, therefore, should be intrusted only to those who will implicitly obey his instructions. If the doctor is not careful to caution his patients as to the danger of overdosing with these agents, he will not be blameless if poisonous effects follow their use. Nor will he have discharged his full measure of duty in this case.

Little pills are not always innocent. Sugar pellets of high potency are potent for neither good nor harm; but the man who

got a bottle of strychnine granules from his physician, with instructions to take one of them three times a day, and concluded to swallow them all at one time, would doubtless have been convinced of their potency had he lived long enough to meditate on the subject. Nature here was not strong enough to resist the action of this powerful drug, or to counteract its effects; but therapeutics might have done something, had she been appealed to early enough to apply the antidote. The only office performed by nature in this case was that she produced the plant that furnished the poison that killed the man.

Nowhere does nature display her incompetency more glaringly than in the treatment of the various dystociæ. The aberrations of function and the obstructions which she suffers to occur, she never relieves; and, were her behests followed, results would be most disastrous. In *previa*, for instance, the strange anomaly is presented of an action, originated by nature in accordance with one of her most beneficent purposes, which is so directly in opposition to the purpose as to destroy two lives at one time. Here the very action which she institutes is the very means employed to kill. This is her most conspicuous fault, when viewed from a medical standpoint, and to her credit be it said it is the only one of the kind to be found in all of her multifarious operations.

Not only should the physician himself be careful in the use of poisonous drugs, but he should give plain and specific directions in regard to the use of the simplest ones. Otherwise he can not expect to obtain their best effects. This was recently demonstrated in the practice of a medical friend who ordered a dose of salts for a lady patient. Her sister, not knowing much about physic, compelled her to swallow a tablespoonful of epsom without water. She found it a very disagreeable potion, and, as might have been predicted, experienced violent emesis instead of the effect desired. Here was an action not intended, and one which could have been easily prevented had the doctor told his pa-

tient, as he should have done, to dissolve the medicine in a tumblerful of water. Such carelessness on the part of the physician brings reproach upon therapeutics and discredit to the profession.

Occasionally, however, unexpected good may come from a misconception of a physician's directions, but this does not follow with such frequency as to enable us to formulate a rule which is safe for the patient to follow. A case to the point recently came under my own observation. A woman got two prescriptions from her physician: one for a liniment and one for internal use. She had been long sick and had but little faith. With an eye to economy she asked her druggist which of the prescriptions was the cheaper. He answered, the liniment. Whereupon she concluded to try this first. Instead of using it externally, as directed, she swallowed a dose. The effect fortunately was prompt vomiting, for the medicine was a poison, and she took one dose only. The result might have been disastrous, but the patient seems not to have been destined to make her exit from the world by the poison avenue. She escaped with her life. Moreover the act was salutary, for the vomiting ruptured an abscess in her throat which had been previously unrecognized, and was thereby promptly cured. When her physician met her some weeks afterward she was in the enjoyment of robust health. He was much surprised to learn that one dose of the wrong medicine had cured her. In neither of the foregoing cases does nature display either medical or surgical skill, but both may serve to show how wisely the Divine Architect has planned the construction of our bodies so as to render difficult the introduction into them of disturbing elements.

We have seen that for the aged nature is any thing but a good physician. She is no better for the young or middle-aged. In very early life her destructive operations are many, for of all deaths in our cities the astonishing fact is disclosed, from mortuary statistics, that forty-six and one half per cent of those who die are under five years of age. This is a sad commentary upon our

boasted civilization and much vaunted sanitary measures. The children of the poor present the largest mortality and contribute the greatest share of any class whose social status has been noted toward bringing about this high rate of mortality. For reasons which are human, nature is almost their only physician, and, not being handicapped by consultations, can do with them as pleases her. Her patients are children, and the therapist would say are therefore most amenable to treatment; for experience shows childhood to be the age of resurrection in medicine; cures during this period being obtained which are impossible in adult life. This is partly due to the hopefulness of childhood, whose life is of the present, occupied with those things that are pleasing to the sight or make to bodily comfort, and unclouded with bitter remorse for the past or evil forebodings of the future. Thus conditioned, the sick child enlists our sympathies, lays claim to the best medical skill, and puts to scorn ignorance, stupidity, and neglect. Nature is its good mother and "kindly nurse" so long as health enables it to conform to her unvarying laws, but when it falls sick she proves herself to be a most incompetent physician.

In the foregoing remarks I have endeavored to show that nature can present no higher claim to the title of physician than to that of surgeon, and that whether the sick be in infancy, in adolescence, in middle life, or in old age, she is incompetent to mitigate their sufferings, or to heal their diseases unassisted by medical or surgical skill. It is therefore the solemn duty of every man who enters upon the practice of our noble profession to fit himself by study, by observation and reflection, to render this timely assistance in accordance with nature's laws.

LOUISVILLE.

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ANTIPYRIN IN PUERPERAL FEVER.—Dr. I Collin, writing in the Finnish Medical Journal, describes two cases of puerperal fever which resisted all methods of treatment until he prescribed antipyrin, under the influence of which both patients rapidly recovered.

## CACTUS, PULSATILLA, AND BROMIDE OF SODIUM IN SOME FUNCTIONAL DISORDERS OF THE HEART.

BY E. J. KEMPF, M. D.

Functional disorders of the heart are of two kinds, first, those cases symptomatic of a diseased condition of the body causing cardiac nerve derangement, and, second, those due to organic nerve lesion. The latter class of cases, comprising angina pectoris and exophthalmic goitre, I will not speak of at present. My paper will be limited to those cases of functional trouble of the heart that are symptomatic.

The diagnosis, prognosis, and treatment of functional disorder of the heart are all dependent upon the cause of the case, and the doctor who does not discover the cause of a functional derangement of the heart will grope in the dark as to his diagnosis, will guess at the prognosis, and will make a botch of the treatment.

Functional disorders of the heart may exhibit themselves in overaction of the heart or feeble action, slow beat or frequent beat, irregular beat and disordered sound. These conditions may occur together; thus, we may find feeble action, frequent beat, irregular beat, and disordered sound or functional murmur in the same case.

The heart is a muscle, and is nourished by blood-vessels and is governed by nerves. It is subject to fatigue and to reflex disorders. Its muscular tissue, connective tissue, pericardium, endocardium, and blood-vessels may be free of disease and yet the heart be out of fix. This we call functional disorder of the heart. Disease of structures in its immediate neighborhood may press upon it and push it to one side, or down, or up, and thus cause the heart to become impeded in its work and thereby deranged in many ways. The causes of this form of derangement are extrinsic, of which we have pressure upon the heart, displacement of the heart, and adhesions of the pericardium. The functional disturbances resulting from these alterations vary of course. They may be temporary, from fluid or gaseous accumulations in the pericardium or any of

the surrounding viscous, from abscess of the liver and great distension of the abdomen or collapse of the abdominal contents.

The symptoms are precordial oppression, pain, palpitation, peculiar sense of lack of breath, often amounting to dyspnea, a weak, irregular pulse, a pale or cyanotic countenance, displaced apex heart beat, a systolic murmur in displacements to the right, due to twisting of the great vessels.

The diagnosis in this class of heart disorder becomes sometimes difficult if not impossible. The prognosis must be guardedly given, especially if the heart trouble is due to rapid gaseous distension of the stomach and intestines, as such cases sometimes prove fatal.

The treatment, of course, must be directed to the cause, which should be removed if possible. The trouble at the heart may sometimes be relieved by the local application of a belladonna or an opium plaster. The patient's fears should also be calmed as much as possible by the assurance that the heart symptoms will not in themselves cause death.

Functional disorders of the heart may be caused by the changed condition of the blood, due to the puerperal state, rheumatism, anemia, and other febrile disorders that cause muscular relaxation. Causes acting through the nervous system are hysteria, chorea, shock, fright, tobacco, alcohol, tea, coffee, excessive venery, overexercise, overstudy, overwork, overeating, trouble, worry, anxiety, excessive joy.

Disorders of digestion, hepatic troubles, bowel complaints, uterine diseases, or in fact any disease of the organ, however remote, by exercising a depressing influence on the nervous system, may produce a functional disorder of the heart.

Heredity is a frequent cause of functional disorder of the heart; that is, the action of the heart becomes deranged more easily in persons predisposed to it from inheritance. It can be therefore readily seen that several causes combined may bring on these troubles of the heart. Thus, the use of tobacco, even if not excessive, may cause palpitation in one predisposed to it, whereas, in a person not so predisposed, the same amount of tobacco would have no deleterious effect.

I will relate some cases illustrative of these various heart troubles:

CASE 1. *Functional Disorder of the Heart in the Puerperal State.* I was called to a farmer's wife, in the seventh month of her fourth pregnancy, who was suffering from heart trouble. I found that she had just recovered from an attack of palpitation, accompanied by dyspnea, fear of impending death, and some pain. The woman was pale, seemingly weak, and in bed. She expressed anxiety about her condition, and was afraid that a recurring of the attack might result in death. Her appetite was fair, her bowels were very much constipated, her urine was cloudy and of a nauseous odor; she had varicose veins of the legs, but not very big ones; her abdomen seemed of a size and shape proper to a seventh-month pregnancy. On palpation, inspection, auscultation, and vaginal examination, I diagnosed a head presentation. Fetal heart-beat one hundred and forty to the minute, and was *regular*; it was heard plainest on the right anterior part of the abdominal wall. A physical examination of the woman's chest showed that the beat of the heart was abnormal in force and in frequency, and irregular in action and in sound. There were sometimes two, sometimes more beats regular, then an intermission, and a systolic murmur of a soft-blowing kind was heard near the apex and not above the precordial region. There was no enlargement of the heart that I could make out, but I supposed that the murmur was caused by a hypertrophy of the left ventricle. There was no history of heart disease previous to her present pregnancy. The patient complained of an uneasy feeling over the heart region, also of a severe headache, and a ringing in the ears.

I assured the woman that there was nothing serious the matter with her, that it was a condition of things often occurring in pregnancy, and that she would fully recover *as soon as her child was born*. I directed a belladonna plaster to be placed over the cardiac region, that the patient take but moderate exercise, that her diet should be moderate but nutritious, that she take a pill composed of aloin  $\frac{1}{8}$  gr., strychnine  $\frac{1}{60}$  gr., and extract belladonna  $\frac{1}{8}$  gr., at bed-time to regulate her bowels, and that she

take a teaspoonful every four hours of the following mixture:

Tinct. cactus (green plant).....	3j;
Tinct. pulsatilla (green plant)..<	3ss;
Bromide of sodium .....	3ij;
Water .....	f. 3iv. M.

The patient had no more attacks of dyspnea, went to term, was delivered of a male child in an easy labor, which was, however, complicated with *post-partum* hemorrhage. After the puerperal period the woman had no further trouble with her heart.

CASE 2. *Unsuspected Heart Disorder.* A young man, twenty-one years of age, applied for admission into an insurance company, and was directed for medical examination to me. His pulse beat 120 to the minute, and was very irregular. He was not aware of the irregularity, had never had palpitation, and was not suffering the least uneasiness. On further examination I could find no apparent cause for the cardiac irregularity and fast beat. The patient seemed in good health, did not use tobacco or alcoholic stimulants, nor was he addicted to masturbation. I put him on the cactus, pulsatilla, and bromide of sodium mixture, and in three weeks his pulse beat 78 to the minute, and was regular.

CASE 3. *Palpitation in Chlorosis.* A girl, twenty years of age, pale and anemic, complained of palpitation, especially at night. Her appetite was poor, her bowels were constipated, her digestion was disordered. Her pulse was small, feeble, and easily quickened. A systolic murmur was discovered near the apex. There was no enlargement of the heart or other sign of a local disease. I gave her the pulsatilla, cactus, and bromide of sodium, the aloin, strychnia, and belladonna pills, Hosford's acid phosphate and pepsin for her digestion, and reduced iron in five-grain doses for her anemic condition. She made a good recovery.

It must be remembered that functional disorders may be associated with organic diseases, and yet may be independent of the latter. The causes that give rise to functional disorders may produce the same effect when cardiac diseases exist. Thus the heart may have serious lesions in rheumatism or in any other acute

disorder, and the vitiated condition of the blood may give rise to functional heart trouble. In these cases I have always used digitalis and other remedies that the symptoms indicated.

Functional heart troubles are apt to occur in cases of anemia. It is my experience that the heart action is apt to be deranged in the anemic condition of the first stage of consumption as well as in the later stages. In these cases I use the cactus and other remedies that the symptoms indicate. Anemia, coexisting with more trivial lesions, may give rise to disturbed action of the heart. It should be treated as one of the symptoms, and the anemia should be considered the disease. In these cases iron, of course, and the cactus, pulsatilla, and bromide of sodium are indicated.

Occurring in connection with plethora, functional heart disorders can be most advantageously treated by a long course at any of the saline purgative springs. The cactus, pulsatilla, and bromide of sodium mixture should always be given in these cases.

Attacks of functional derangement of the heart from tobacco, alcohol, tea, coffee, etc., are quite frequent. They are cases of so-called irritable heart, and can always be relieved by discontinuing the narcotic that causes the trouble and by taking the cactus, pulsatilla, and bromide of sodium mixture, accompanied with the application of a belladonna plaster over the region of the heart.

Occurring in connection with hysteria and nervousness, fright, etc., functional disorders of the heart can be relieved by the cactus, pulsatilla, and bromide of sodium combined with valerian. Of course other remedial measures may be indicated, and, if so, should be prescribed.

Cactus mentioned in this paper is the tincture (green plant) of the *Cactus grandiflora*, a night-flowering species of the natural order cactaceæ, some five hundred in number. The plants of this order are a great boon to the regions in which they abound; their stems contain a store of insipid and wholesome juice, of which both men and cattle avail themselves.

It has been recommended by eclectics "to relieve the unpleasant symptoms in heart dis-

ease, and to give tone to the nervous system controlling the heart."

Pulsatilla is described in Wood's Reference Hand-book of the Medical Sciences as a remedy extensively used in homeopathic practice as a sedative for the heart. Eclectic literature says of it: "It relieves the irritation of the nervous system, nervousness, fear of impending death, dizziness, mental depression, etc."

The bromides have long been used in functional disorders of the heart, and the sodium bromide is generally preferred, because it is less unpleasant to the taste than potassic bromide, and is in every way less deranging of function. It is milder in its effects on the stomach and causes no derangement of the bowels.

The following are the points that I have tried to make clear in my paper:

1. That functional disorders of the heart are, as a rule, symptomatic diseases, and should be treated as such.

2. That the danger to life is exceedingly small from the heart trouble.

3. That no strict plan of treatment can be formulated.

4. That tincture cactus, tincture pulsatilla, and bromide of sodium in combination are useful in some functional disorders of the heart.

5. Assurance that the disorder is a trivial one should always be given the patient.

6. Local applications, plasters, sinapisms, ice-bags, etc., may be used with benefit.

JASPER, IND.

No GOOD.—Patent medicine man (to editor): "You made a nice mess of that testimonial advertisement."

Editor: "How?"

Patent medicine man: "John Smith wrote: 'Your Live Forever Pellets are doing me a great deal of good. Send me another box; and I told you to give it a prominent place.'"

Editor: "I did—immediately preceding the death notices."

Patent medicine man: "Yes, and the first death notice on the list was that of John Smith!"—*Tid Bits*.

## Reviews and Bibliography.

**Favorite Prescriptions of Distinguished Practitioners**, with Notes on Treatment. By B. W. PALMER, A. M., M. D. Pages, 256. Price, \$2.75. New York: E. B. Treat. 1888.

This work is a compilation of favorite prescriptions employed by a number of the best-known writers on therapeutics, from which selections are made. Among the names are found a few who were themselves compilers and book-makers only, and others who are noted for their unlimited faith in medicines and the uniform success they claim. Such men, of course, are doubtless good enough authority on right proportions and neatly arranged prescriptions, but the "busy practitioner" or the student who starts out with the teaching of such men, and then comes to observe and think for himself, will find that he has a large latitude for disappointment. Still, the practice of writing prescriptions is a profitable one in an educational point of view, and this book offers a very creditable selection of forms. A book, however, presenting in a clear and succinct form the rules by which prescription-writing is regulated and the principles upon which it is based would prove a much more profitable study.

D. T. S.

**Diseases of Man: Data of their Classification and Genesis.** By W. S. GOULEY, M. D., Surgeon to Bellevue Hospital. Pages, 412. New York: J. H. Vail & Co. London: H. K. Lewis. 1888.

In this work Dr. Gouley presents a large amount of valuable information on the proper nomenclature of diseases, gathered from a wide range of sources. It is especially valuable as giving the history of all the most important efforts at the classification and nomenclature of disease. The author rightly concludes that to be effectual a system of nomenclature should be the work of an international congress. No one can fail to see the impossibility of adapting a nomenclature of diseases thoroughly satisfactory in the present state of medical

knowledge. Nor, when we reflect, after examining other branches of science, how few men possess the genius and learning for giving a descriptive nomenclature, can we fail to conclude that an international congress can do little more than indorse such a work after it is done. Interesting discussion of the nature of this work of Dr. Gouley can not fail to awaken in the profession an interest in this desirable undertaking.

D. T. S.

**Text-book of Medical Jurisprudence and Toxicology.** By JOHN J. REESE, M. D. Second edition, revised and enlarged. Pages, 606. Fine cloth, \$3; leather, \$3.50. Philadelphia: P. Blakiston, Son & Co. 1889.

It is not easy to name a subject legitimately connected with medicine upon which physicians are more ill-informed as a rule than upon medical jurisprudence. Four fifths, perhaps, of the occasions upon which medical men come to shame arise in connection with questions growing out of this subject. One reason for this has been that most of the works upon this branch have been too large and exhaustive to invite study on the part of those who were not advised as to the value of such knowledge. This difficulty has been largely overcome by a number of works recently issued, and notably by this work of Professor Reese. With a work on medical jurisprudence so clearly written, smooth in style, and interesting as this, no one has any longer an excuse for not gaining a fair familiarity with legal medicine.

D. T. S.

**A Text-book of Human Physiology.** By AUSTIN FLINT, M. D., LL. D. With three hundred and sixteen figures in the text and two plates. Fourth edition, entirely rewritten. Pages, 872. Price, cloth, \$6; sheep, \$7. New York: D. Appleton & Co. 1888.

As a text-book for students in this country we have no hesitation in pronouncing this the best yet written on the subject of physiology. It presents a concise and connected statement of well-established facts in a form that they can easily be acquired

by students, and in a language that can not be misunderstood. It is free from elaborate descriptions of apparatus and methods that so often burden the pages of treatises of this character, and which are seldom read and almost never understood by students who have not such apparatuses at hand, and, indeed, should not be read to the sacrifice of valuable time. If every student were required to be a graduate in physics, as in European countries, intricate mathematical calculations, such as are involved in optics and acoustics, might be in place; but in this country they involve only a waste of time and confusion.

The typography and mechanical execution of the work are all that would be desired. In one chapter only, that on Generation, Professor Flint is less happy than Dalton, although he introduces a number of more recent and valuable observations. For the present it is *the American text-book on physiology*.  
D. T. S.

**1. The Modern Treatment of Diseases of the Liver.** By Professor DUJARDIN-BEAUMETZ. Translated by E. P. HURD, M. D. Pages, 185. George S. Davis. 1888.

**2. Abdominal Surgery.** By HAL C. WYMAN, M.S., M.D. Pages, 87. George S. Davis. 1888.

**3. Treatise on Hysteria and Epilepsy,** with some concluding Observations on Epileptic Insomnia. By LEONARD J. CORNING, M. A., M. D. Pages, 176. George S. Davis. 1888.

These three volumes are a part of the Physician's Leisure Library series of Geo. S. Davis, of Detroit, who has done so much to supply the profession of the country with choice medical literature in a cheap form. The several subjects are well treated, and all present profitable reading.  
D. T. S.

**Clinical Lectures on Albuminuria.** By THOMAS GRAINGER STEWART, M. D., Edinburgh. Pages, 250. New York: William Wood & Co. 1888.

Whoever takes interest in the question of albuminuria, which has of late years become one of so much importance, will here find presented in a very attractive form the essential points of all that is known on the

subject. Mr. Stewart, one of the foremost teachers, a man of eminent ability, has here given us the result of an exhaustive study of the literature of the subject, and added thereto his own extensive observations. The work will well repay a careful study.  
D. T. S.

**Medical Diagnosis: A Manual of Clinical Methods.** By J. GRAHAM BROWN, M. D., Fellow of the Royal College of Physicians of Edinburgh. Second edition; illustrated. Pages, 285. Price, \$2.75. New York: E. B. Treat. 1888.

This work is characterized by the terseness, elegance of style, and learning for which the Edinburgh school is so highly distinguished, but it appears to embrace entirely too much in the compass of its pages. It is not by far sufficiently illustrated, and the tabular method is too seldom employed. In this age, when the closest application and study enables one to get in an ordinary life-time only an inkling of what is really known in any branch of science, we need facilities for employing all our senses in the pursuit of knowledge. The work will answer excellently for one who would review, but poorly for the learner.  
D. T. S.

Transactions of the American Ophthalmological Society. Twenty-fourth Annual Meeting, New London, Connecticut, 1888. Hartford: Published by the Society. 1888.

Transactions of the American Surgical Association. Volume the sixth. Edited by J. Ewing Mears, M. D., Recorder of the Association. Philadelphia: Printed for the Association, and for sale by P. Blakiston, Son & Co. 1888.

Transactions of the American Dermatological Association, Twelfth Annual Meeting, September 18, 19, and 20, 1888, in connection with the First Meeting of the Congress of American Physicians and Surgeons. Official report by the Secretary, G. H. Tilden, M. D. Boston. 1888.

Hand-book of Materia Medica, Pharmacy, and Therapeutics. Compiled for the Use of Students Preparing for Examination. By Cuthbert Bowen, M. D., B. A., Editor of "Notes on Practice." Philadelphia and London: F. A. Davis, Publisher. 1888. Price, \$1.40 net.

Essay 54: Therapeutics can Become a Science. By William Sharp, M. D., F. R. S. "Scientific Method: Conclusions are not evolved out of the inner consciousness; they are suggested by a large collection of facts." (J. B. Lightfoot.) London: George Bell & Sons, York Street, Covent Garden. 1889.

A Reference Hand-book of the Medical Sciences, embracing the Entire Range of Scientific and Practical Medicine and Allied Science. By various writers. Illustrated by chromo-lithographs and fine wood engravings. Edited by Albert H. Buck, M. D., New York City. Volume 7. New York: William Wood & Company, 56 and 58 Lafayette Place. 1889.

The Physician's Leisure Library: Bright's Disease of the Kidney. By Alfred L. Loomis, M. D., LL. D., Professor of Pathology and Practice of Medicine, New York University Medical College; Visiting Physician to Bellevue Hospital; Consulting Physician to St. Luke's and Mt. Sinai Hospitals, etc. Detroit, Mich: George S. Davis. 1888.

International Pocket Medical Formulary, with an Appendix containing Posological Table, Formula for Inhalations, Suppositories, Nasal Douches, Eye-washes, and Gargles, Hypodermic Formula, etc. By C. Summer Witherstine, M. S., M. D., Associate Editor "Annual of the Universal Medical Sciences," late Home Surgeon Charity Hospital, New York, etc. Philadelphia and London: F. A. Davis, Publisher. 1888.

The Operations of Surgery: A Systematic Hand-book for Practitioners, Students, and Hospital Surgeons. By W. H. A. Jacobson, F. R. C. S., Assistant Surgeon, Guy's Hospital; Teacher of Operative Surgery and Joint Teacher of Practical Surgery in the Medical School; Surgeon to the Royal Hospital for Children and Women. With one hundred and ninety-nine illustrations. Philadelphia: P. Blakiston, Son & Co., No. 1012 Walnut Street. 1889. Price, \$5.00.

The Functions and Disorders of the Reproductive Organs in Childhood, Youth, Adult Age, and Advanced Life, considered in their Physiological, Social, and Moral Relations. By William Acton, M. R. C. S., late Surgeon to the Islington Dispensary, and formerly *externe* to the Venerable Hospitals of Paris, Fellow of the Royal Medical and Chirurgical Society, etc. Seventh edition. Philadelphia: P. Blakiston, Son & Co., 1012 Walnut Street. 1888. Price, \$2.00.

The Year-Book of Treatment for '89, being a Critical Review of the Practice of Medicine and Surgery during 1888. Contributors: J. M. Bruce, M. D., Alfred Cooper, F. R. C. S., Sidney Coupland, M. D., Sir Dyce Duckworth, M. D., G. P. Field, M. R. C. S., J. F. Goodheart, M. D., Reginald Harrison, F. R. C. S., D. Berry Hart, M. D., G. E. Herman, M. B., Robert Maguire, M. D., Peter McBride, M. D., Malcolm Morris, F. R. C. S. E., etc. Philadelphia: Lea Brothers & Co. 1889. Price, \$1.25.

Hand-book of the Diagnosis and Treatment of Diseases of the Throat, Nose, and Naso-pharynx. By Carl Seiler, M. D., Instructor in Laryngology and Lecturer on Diseases of the Upper Air-passages in the University of Pennsylvania; Chief of the Throat Dispensary at the University Hospital; Physician-in-Chief of the Union Dispensary, etc. Third edition, thoroughly revised and greatly enlarged. Illustrated with two lithographic plates containing ten figures, and one hundred and one wood engravings. Philadelphia: Lea Brothers & Co. 1889.

Electricity in the Diseases of Women, with Special Reference to the Application of Strong Currents. By G. Betton Massey, M. D., Physician to the Nervous Department of Howard Hospital; late Electro-therapist to the Philadelphia Orthopedic Hospital and Infirmary for Nervous Diseases; Member of the American Neurological Association; of the Philadelphia Neurological Society; of the Obstetrical Society of Philadelphia; of the Medical Jurisprudence Society; of the Franklin Institute, etc. Philadelphia and London: F. A. Davis, Publisher. 1889. Price, \$1.50 net.

## Correspondence.

### LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

At the annual meeting of the Governors of the Seaman's Hospital Society at Greenwich, the committee of management congratulated the governors and subscribers on an increased revenue. The receipt of the Queen's subscription of one hundred guineas was gratefully recorded. There were 2,463 patients under treatment in the wards of the hospital at Greenwich, the largest number in any one year since the hospital was re-

moved on shore from the old three-decker which used to be such a familiar sight in the Thames; 5,914 out patients were treated at the hospital and the dispensaries at Well Street and Gravesend. This showed an increase of 1,032 above the average of the last ten years. Steps had been taken to erect a branch hospital in the vicinity of the Albert and Victoria Docks at the first expenditure of £3,000, and it would cost about £1,000 per annum to maintain.

An interesting case of hysterical sneezing cured by suggestion in the waking state comes from Belgium. The patient was a girl, about thirteen years of age, who had already presented some slight symptoms of hysteria. At the time she was seen by Dr. Derechter she had been suffering for a fortnight from incessant sneezing, which occurred as often as thirty to forty times a minute, and was accompanied by no secretion. During the night the girl enjoyed sound sleep. The veteran surgeon, Dr. Crocq, having insisted on the girl ceasing to sneeze, the affection ceased at once. A mixture containing bromide of potassium was then ordered. Next day coryza declared itself, with very abundant secretion, and this coryza was followed by a tracheo-bronchitis, but the sneezing did not return. Dr. Derechter cites a certain number of cases of hysterical sneezing observed in England by Sir Benjamin Brodie, and in France by Dr. Charcot. All these cases were characterized by convulsive sneezing, not accountable for by the ordinary reflex nervous action. Dr. Derechter asks whether there is not a psychic element in play, since the ailment yields readily to "suggestion." In the present case the patient was of an extremely sensitive nature. She was caused to forget her own name, and was deprived of speech for some time. After being told she could not speak, when she was sternly enjoined not to sneeze the affection ceased immediately, and this was done without the use of hypnotism. Mr. Braid, a Manchester surgeon, was the first in England to introduce the art of putting his patients into a hypnotic sleep, and operated them successfully while in this condi-

tion. Many years afterward the same process for operating without the use of chloroform or ether was reproduced in the Paris hospitals and elsewhere. At present there is a commission in Brussels inquiring again into the matter.

There has long been a popular belief that the greatest number of deaths occur between four and six o'clock in the morning. A medical man has taken the trouble to tabulate the death hours of all patients dying in two large general hospitals during the last ten years. He found that there were rather fewer deaths between seven and eleven o'clock in the evening than at any other time, but there was no special preponderance at any hour.

Suicide is greatly on the increase in France, according to a Parisian physician who has been interviewed on behalf of an English paper published in the French capital. While in London the proportion annually of suicides per million is reckoned at eighty-seven, and in Naples thirty-four, it is in Paris four hundred and two.

Dr. Sidney Phillips thinks that the murmur sometimes heard in the subclavian artery just below the clavicle is systolic in time, but is sometimes only heard during or much intensified by inspiration, and is usually rough and abrupt in character; it was commoner in adult females than in males or children, and much more often heard on the left than on the right side. He looks upon it as an ordinary hemic murmur, similar to those heard in other arteries and produced by the same conditions, but heard usually only below the clavicle, because the first part of the artery was within the thorax and not readily auscultated. These conditions were two, namely, insufficient filling and defective forms of the arteries. The influence of respiration Dr. Phillips attributes to the physiological result of the inspiratory enlargement of the chest, which decreases the blood pressure in the large arteries, and the frequency of the murmur on the left side was due to the greater length of the artery within the thorax on the left side, exposing it more to the influ-

ence of the respiratory movement. In conditions other than anemia in which the murmur is heard, such as atheroma of vessels, debility of convalescence, etc., the factors are present, as in anemia, to alter the relationship between the arterial caliber and its contained blood. With regard to the subclavian and pulmonary artery murmurs, which have been described as significant of phthisis, they are in most cases the result of co-existent anemia, the former being sometimes heard on both sides when one lung only showed signs of phthisis, and if in any case produced by phthisis, the murmur results, not from consolidation of lung pressing upon the artery but from impaired pulmonary expansion leaving the artery unsupported. Dr. Phillips further thinks the murmurs in the aorta and pulmonary artery in anemia are often influenced in rhythm by the respiratory movements, the aortic murmur being best or only heard during inspiration, while the pulmonary murmur is sometimes only heard during expiration; the difference being probably due to the different effects of inspiration on the blood pressure in the systemic and pulmonary vessels, for in the former the blood pressure was decreased, in the latter increased during inspiration. He considers anemic murmurs in the innominate and left common carotid trunks within the thorax are not infrequent in anemia. The murmur found in atheromatous arteries was, he believes, caused by the artery being incapable of fitting itself to variations in the blood current.

In the last official returns of the general post-office it is shown that fifty per cent of the telegraph clerks who retire are obliged to do so owing to permanent derangement of the brain and nerves, due to the peculiar and arduous nature of their work.

Antipyrin has been used by Mr. Montagu Percival in twenty-four cases of laryngismus stridulous, two grains every hour. With one exception the paroxysms were arrested, and in the latter case the dyspnea was relieved with five grains.

Experiments recently carried out have shown that the addition of an acid to the

solution of corrosive sublimate increases its power as an antiseptic to such an extent that it may be used in a much weaker solution than has hitherto been the case. In a considerable number of experiments in which the bichloride-of-mercury solution was used as an antiseptic for surgical dressings, it appeared that albuminate of mercury was often formed, which is insoluble, and the antiseptic dressing ceased to act. To avoid this, tartaric acid was added, which causes no irritation to the wound. The solution in which the gauze, cotton, or linen is steeped is composed as follows: Corrosive sublimate one gram, tartaric acid five grams, distilled water one thousand grams.

The first idiot asylum has just been opened in Italy at a town in Liguria. It will be conducted on the same lines as the most successful asylums of the same class in England. It will receive, and as far as possible educate, patients between seven and twenty years of age from any part of the kingdom. It is intended to speedily erect other institutions in various parts of the State.

LONDON, February 2, 1889.

#### LETTER FROM CINCINNATI.

Dr. W. W. Dawson, President of the American Medical Association, says that arrangements for the next meeting at Newport are going on nicely, and the meeting promises to be one of the best in the history of the society. Cincinnati furnishes this year the president, several of the officers, and a big delegation.

Trained nurses are to take charge of the Cincinnati Hospital the first of April. Female nurses are to be employed in both the male and female wards, and a matron will be placed in charge of all the wards. Miss Murray, who came here from Philadelphia, where she occupied the position of superintendent of the school for trained nurses, is to occupy the position of matron.

A certain Cincinnati doctor recently received a package accompanied with a letter. The writer said they had long appreciated the doctor's efforts in their behalf, and hoped he would accept the accompanying testimonial of the

regard for the good work in which he was engaged and the eminent success which crowned his efforts. The letter was from the Cincinnati Coffin Company, and the package inclosed a miniature coffin arranged as a paper-weight. The doctor says it is the only "case" of the kind he has ever received, and considers it unique in many respects.

The annual contest among the students of the Medical College of Ohio for the prizes in bandaging, drawing, and dissecting, given by Dr. Dawson, occurred recently at the Good Samaritan Hospital. The contest was one of great interest, and was witnessed by the class at the college and a number of visiting physicians. After the contest competition was finished, a number of speeches made (some of them very good), and several clinical cases shown, the guests repaired to partake of an excellent repast spread for them. The results of the contest are in sealed envelopes, and will be made known at the commencement.

Dr. J. T. Whittaker, Professor of the Practice of Medicine in the Medical College of Ohio, and Physician to the Cincinnati Hospital, in a recent exhaustive article on the history of tuberculosis defines this disease as follows: Tuberculosis is the specific infectious disease produced by tubercles, which are in turn special products of a distinct micro-organism known as the bacillus tuberculosis, or, from its discoverer, bacillus Kochii. The history of tuberculosis divides itself into five periods. The first is the period of ancient history. During all this period the disease was observed only from a clinical standpoint. The second period, beginning with the birth of anatomy, in the sixteenth century, furnishes the first definite knowledge regarding changes or lesions of structure. The third period followed the publication of Bayle and Laennec, in the first quarter of the nineteenth century, declaring tuberculosis a separate affection due to the deposit of tubercle; a specific product, independent of ordinary inflammation. This period is made more memorable by the discovery of auscultation as a means of diagnosis. It was the genius of Laennec in the discovery of auscultation which first rendered possible the diagnosis of the disease in life. The fourth period was introduced

late in the last half of the nineteenth century, with the inoculation experiments of Villemin, 1865; and the fifth was announced with the brilliant revelations of Koch, 1882, regarding the cause of tubercle and the etiology of the disease. The contribution of Koch he describes as the most remarkable which has ever been made, with each link in his chain of evidence equally strong, because each and every link was forged by his own hands. The discovery of the tubercle bacillus gave the final death blow to the doctrine that the disease was ever secondary in any sense. The specter of inflammation which perpetually stalked to the front to obscure the true nature of the disease was quieted forever. Instead of producing the disease, inflammation itself is relegated to a secondary place in pathology, as a mere result of infection. Thus, not with a side light but with a light in its very center, has Koch illuminated this most obscure disease, and though shadows still hang about the borders, they must be gradually dissipated with the penetration of its rays in time. We may therefore sum up the history of tuberculosis by noting that it was first regarded as a process of suppuration (pus); then as consisting of nodules; in the third period there are seen to be distinct tubercles; fourthly, these tubercles contain a virus; and in the final period this takes shape in the tubercle bacillus.

The doctor found the following conclusions, published in England a few years ago, to be very much in accord with his ideas:

That tubercle is a true zymotic disease of specific nature, in the same sense as typhoid fever, scarlet fever, typhus, etc.

That, like these diseases, tubercle never originates spontaneously, but is perpetuated solely by the law of continuous succession.

That the tuberculous matter itself is (or includes) the specific morbid matter of the disease, and constitutes the material by which phthisis is propagated from one to another and disseminated throughout society.

That the deposits of the matter are therefore of the nature of an eruption, and bear the same relation to the disease, phthisis, as the fecal matter of typhoid fever.

That by the destruction of this matter on its

issue from the body by means of proper chemicals or otherwise, seconded by good sanitary conditions, there is reason to hope that we may eventually and possibly at no distant time rid ourselves entirely from this fatal scourge.

Etiology of Diphtheria was the subject of a paper read before the Cincinnati Academy of Medicine recently by Dr. B. K. Ratchford, bacteriologist to the Medical College of Ohio. He stated as the object of his paper the discovery of the truth or falsity of the opinion that diphtheria is a local disease, and that the constitutional symptoms are produced by poisonous materials absorbed from the local lesion; and to study certain other points relating to the etiology of this disease. After a thorough discussion he arrives at the conclusion that the constitutional symptoms of diphtheria, including the after paralysis, is produced either directly or indirectly by ptomaines. Immunity he found a most obscure chapter.

In conclusion the doctor summarized the following conclusions:

1. Diphtheria is a purely local disease.
2. It is caused by an external parasite.
3. This parasite is practically if not strictly aerobic.
4. The constitutional symptoms are due to the absorption of poisonous materials, viz., ptomaines from the local lesion.
5. The changes occurring in the blood and tissues, including the nerve lesions, are caused by direct or indirect action of ptomaines.
6. The disease has no latent stages, and second and third attacks are due to reinfection.
7. One attack, as a rule, gives at least temporary immunity.
8. After the limited period of immunity has expired, the previous attack may act as a predisposing cause to other attacks, if it has left the mucous membrane of the throat in an irritated and inflamed condition. This is more likely to occur in scrofulous subjects.

9. Complications may occur from the entrance into the body of septic germs.

Upon these points he lays down the following rules of treatment:

1. Dissolve away the membrane if possible, and irrigate the local lesion thoroughly and frequently with an antiseptic solution, for the

double purpose of washing away the poisonous alkaloids and retarding the growth of the parasites.

2. In diphtheria of wounds, and in other parts where it is practicable, the thorough irrigation should be followed by a dressing which would exclude atmospheric air. This on account of the aerobic nature of the germ.

3. We should try to rid the system of the poisonous alkaloids by mild catharsis, free diuresis and diaphoresis, with remedies which do not have a depressing action on the heart.

4. We should seek to counteract the depressing effects of this poison on the heart and other tissues by abundant stimulation.

5. We should also seek to counteract its deteriorating influence on the blood by free exhibition of the great blood-restorer, iron.

6. We should render the air of the sick-room as nearly aseptic as possible, to prevent the entrance of adventitious septic germs.

7. Chronic glandular enlargement and other disease remaining about the throat should be cured before dismissal, else the patient warned against future exposure to diphtheritic poison.

8. The patient should not be entirely dismissed from observation for two months, during which time he should receive tonics and good food.

9. A serious exacerbation of the symptoms in any form of ulceration or catarrh of the stomach or intestine occurring in a patient exposed to diphtheria should lead us to suspect the disease in these parts, and we should treat it accordingly.

E. S. M'KEE, M. D.

## Abstracts and Selections.

OBSTETRICS AND GYNECOLOGY.—(By E. S. McKee, M. D., Cincinnati.) Menstruation, that ever-recurring phenomenon in woman, will always continue to be a subject of interest to the student. Theories in great numbers have been advanced as to its causation and nature. A most interesting paper on the Disorders of Menstruation was read by Dr. Andrew F. Currier, of New York, before the New York State Medical Society at Albany, February 6, 1889. He classified these disorders as follows:

1. Amenorrhea, absence of the menstrual flow.

2. Dysmenorrhea, the condition in which the menstrual flow is obstructed.

3. Oligomenorrhea, scantiness or insufficiency of the menstrual flow.

4. Polymenorrhea, excessive menstrual flow.

5. Atopomenorrhea, out of place, unwonted, vicarious menstruation.

Races or tribes less removed from animals resemble the latter mostly in this respect. Nervous women usually experience more or less discomfort in menstruation, frequently suffering from dysmenorrhea and oligomenorrhea. Great abnormalities in the menstruation may be produced by influences located in the vascular system. A scanty flow may be the result of a weak heart, and a profuse one follow a strong action of the heart. Great elevations with diminished atmospheric pressure favor profuse menstruation. A humid atmosphere is frequently a concomitant and probably a cause of amenorrhea or dysmenorrhea or oligomenorrhea, owing to a change of the pressure arrangements between the atmosphere and the fluids and gases of the body. Menstruation occurs earlier in hot climates than in cold. Extreme cold is always unfavorable to the regular and easy performance of the menstrual function. Amenorrhea be considered as not referring only to those who suffered from retention of the menses; it may obtain with those who have passed the menopause, whether prematurely or not. It may be due to mechanical obstruction, to the debilitating effect of wasting disease, to humid atmosphere, cold, etc. Dysmenorrhea includes those cases where there is an obstruction, either mechanical or chemical, to the outflow of the blood. Pain is usually present, but not necessarily. It may be due to weak heart action or deficient contractile power of the uterine muscle. It may be associated with subinvolution, with uterine displacements, obstruction by tumors, and obstruction by hypertrophied mucous membrane. It may also be caused by various atmospheric conditions, abnormal constituents of the blood, or the normal constituents in great excess. The specific gravity being greatly increased may act as a sufficient cause. Oligomenorrhea may persist during pregnancy, and may be due to deformities or want of development of the organs, to uterine displacements, or to obesity, or to anemia. Polymenorrhea appearing at the time of the menopause indicates underlying disease. It calls for the most active repressive treatment of all the forms of menstrual disorder. Cooks and laundresses and others

exposed to great heat are predisposed to this disease. Abuse of the sexual act also is an etiological factor. Vicarious menstruation is a term which Dr. Carrier considers inexact and inaccurate. Its synonym, *xenomenia*, is a term which is etymologically correct. Displaced menstruation may occur, as bleeding from the nose, gums, lungs, stomach, rectum, or anus; from nevi, ulcers, fissures, fistulae, and nipples; from the anterior chamber of the eye and the external auditory meatus; or it may appear as extravasation into or through the skin in the form of bloody sweating purpura, acne, etc. All these facts tend to show that the monthly congestion in women is not local, but general, or at such times as the vascular tension is so raised that vessels which are near the surface are much more liable to rupture than under ordinary circumstances or conditions of tension and pressure. The paper of Dr. Carrier is well worthy a careful perusal, but this *resumé* is given for those who have not this privilege.

The Paris Obstetrical and Gynecological Society has elected the following officers: President, M. Polaillon; Vice-Presidents, M. Dumontpallier and M. Bailly; Treasurer, M. Porack; Secretaries, M. Greslon, M. Charpentier, M. Rey, and M. Verrier.

Antipyrine in painful menstruation has been used by Windelschmidt by means of enemas of thirty grains in severe cases of cramp and colic in menstruation. An excellent sedative effect occurred generally within a half hour, and usually proved sufficient, though in some cases the injection had to be repeated after twelve hours. Wonderful success was attained in two cases where the pain was very severe and continued through the entire eight days of menstruation. This relief was generally accompanied by narcotic effects, the patient falling asleep and waking entirely free from pain. There was no unfavorable action noticed except profuse sweating and frequently slight ischuria. The administration of a glass of wine prevented collapse.

Pregnancy as a remedy for exophthalmic goitre is discussed in *Progrès Médical*, and the observation of Charcot, illustrating the ameliorating influence of pregnancy on exophthalmic goitre, is the history of a case in which the same effect seemed to be produced. It concludes that this phenomenon points to an additional therapeutic resource in that disease, but admits that it is not always easy or expedient to carry out the prescription.

The treatment of metrorrhagia and pro-

fuse menorrhagia in Briesky's clinic of Obstetrics and Gynecology in Vienna, when due to the retention of the secundines in abortion, is based on the following plan: (1) Disinfection of the genitalia. (2) Slow dilatation by small aseptic bougies prepared for this purpose. (3) Disinfection of the uterus and exploration by the finger to ascertain the situation and nature of its contents. (4) Removal of the morbid material with the polypus forceps and redisinfection. If the abortion has occurred some weeks previously, and the cervix is again closed, and the hemorrhage continues in spite of the treatment, the woman is placed in the dorsal position, the external genitals and vagina disinfected with a three to five-per-cent solution of carbolic acid lukewarm, and the anterior lip of the uterus brought well down with a vol-cellum. One or two tents, according to the size of the cervix, are then introduced and pushed well up. Silk threads are attached to the external ends of these tents, which are boiled before using in a five-per-cent solution of carbolic acid and dried in iodoform or sublimate gauze.

Previous to insertion the tent is immersed in a solution of carbolic acid and vaseline. After about eight hours the cervix is usually dilated so that it is not necessary to reintroduce the tents, the finger readily passing into the uterine cavity. The tents are then removed and the uterus irrigated with a solution of carbolic acid. Corrosive sublimate is not used, owing to the danger of intoxication. The patient is placed in the dorsal position, the shoulders elevated so as to prevent the introduction of air. Briesky's canula is then introduced through the cervix, and, by altering the direction of the stream, all parts of the uterus are thoroughly disinfected. The finger then carefully explores the uterus and locates the retained membranes, when they are removed by the polypus forceps. The cavity is again disinfected, a bougie of iodoform introduced, and the vagina tamponed. Ergotin is given every hour. Prof. Briesky, fearing laceration of the cervix, is opposed to dilatation by sounds or dilators. The polypus forceps are superior to the curette, and less likely to perforate the uterine walls.

**THE TREATMENT OF SUPPURATION OF CAVITIES WITH RIGID WALLS** was the subject of an address before the Medical Society's meeting of the 19th ult., by Herr Küster. Alluding to the method of treatment until lately in general use, viz., the employment of syringing he calls a wretched shift, and remarks that treat-

ment that rests on repeated syringing through a single opening may be designated as faulty, and decidedly capable of improvement, reminding one of the times when treatment of wounds was given over to the barber with his sponge and syringe. He divided suppurating cavities into two groups, according as one wall is rigid, the other being formed of organs capable of stretching, or as the whole cavity is surrounded by rigid walls. The type of the first group was empyema, the treatment of which he proceeded to discuss. The simplest form was that of an empyema filling the greater part of the thorax so that it was perceptible both before and behind. He made an incision in any favorable spot in the anterior wall, letting the pus flow freely out. From this point a long sound was introduced, and the lowest point of the pleural cavity sought by means of it, and when the end of the sound was felt the rib lying nearest above it was resected. If the deepest point was not found at first, this could be remedied by prolonging the incision downward and outward, and removing another piece from the resected rib. He did not hesitate, if required, to resect a second rib at the lowest point. There was no danger of wounding the diaphragm.

The case was different where an encapsuled exudation lay posteriorly and could not be detected from before. After its limits had been made out by percussion, the rib lying nearest to the lowest point was resected. If the collection was small, a simple incision sufficed, the cavity was then tamponed and the lung speedily expanded. If the exudation was greater it would be necessary to make a second opening above and pass a drainage-tube straight through both openings. Those cases were the worst in which an unsuitable operation had been performed long before, where a fistula had been in existence for months or years, and the patients were miserable and exhausted, or the empyema had burst before operation, leaving behind an internal, or external, fistulous opening. In these cases attention must be paid to diminishing the size of the thorax, and this was done by resecting two ribs in the vicinity of the fistula, or of two or three ribs posteriorly. For those cases in which the lungs were contracted into a firm large mass the procedure was of no use. Schede formed a large flap of the soft parts, reflecting it as far as the upper part of the thorax, and resecting the greater portion of the ribs together with the intervening soft parts. He had himself several times performed the operation; the result was not in the least satisfactory. He did not advise the operation, except in the case of tubercular empyema.

He was of opinion that statistics must supply the last word, and he therefore brought forward the results of his own operations, which were 109 in number. 60 cases were cured (55 per cent), 17 remained uncured (15 per cent), including those cases the result of which was undetermined; 30 died (or 29.35 per cent). The only record of large numbers that showed a more favorable result, and fewer deaths, was that of Naunyn. Naunyn's record, however, contained much fewer tuberculous cases than his own, and he believed that the results showed that his own mode of operation was better than any other. In further grouping his cases, in 39 uncomplicated cases 34 were cured (87 per cent), 4 died (10 per cent), one of them being a case of carbolic poisoning. This was the best result that had ever been obtained. Next followed a group that had been previously and ineffectively treated, consisting of 15 cases; 8 were cured and 6 died. The next group, of 3 cases, had gangrene of the lung; 1 was completely cured, 2 died. Three cases were complication of noma, basilar meningitis, etc.; all died. The tuberculous group comprised 31 cases; 6 were completely cured (19 per cent), 10 remained under treatment, 14 died (45 per cent). If in old cases patients were relieved so far that they could get about with a thoracic fistula, he would consider the operation a boon, for before it they lay in bed struggling for breath and nearly suffocating, while in a few days or a week after the operation they were able to get about, and even go into the open air.

He next defended the operation against the objections of difficulty, danger, and permanent injury to the body entailed by it, and passed on to those cavities in which the walls were formed wholly or for the most part of bone covered by mucous membrane. These were all pre-formed cavities. When suppuration had once become established here, healing could only take place either by a return of the membrane to its normal condition or by atrophy of it. In these cases also it was advisable to operate early at the lowest part of the cavity so as to prevent stagnation. The antrum was the type of these cavities. Bernard Fraenkel had treated the subject exhaustively near eighteen months before at the Berlin Medical Society. Three methods of opening the cavity were to be distinguished, (1) the oldest form, that of opening from the alveolus; (2) the somewhat later form of opening from the facial wall, and (3) the newest, that from the nasal channel. Fraenkel pronounced in favor of the latest, as the other two methods permitted the entrance of particles of food into the cavity. There were strong objections to the first and last

methods; the only reliable one was that from the facial wall. This operation could be performed without chloroform, by using cocaine to the mucous membrane. It should be performed subperiosteally. He made an incision from the first premolar to the first molar tooth through mucous membrane and periosteum, raised up the soft parts, and with a scalpel cut through the anterior wall so far that the lower edge of the wound was on a level with the lowest point of the cavity. With the little finger introduced through the opening, the whole cavity could be examined, and if it was then syringed out and plugged with iodoform gauze, the suppuration generally ceased in a short time so that the cavity could heal up.

The relations were the same in the frontal sinuses. They did not tend to open into the nose but through the orbital wall. They were generally opened at this point, but it was not the lowest, and it was best to restore the natural outlet into the nose in order to prevent recurrences. He did this with the curved trocar or the sharp spoon, then inserting a fine drainage-tube, leaving it in so long as the discharge remained purulent. It was then replaced by a silk thread, and this at last removed.—*London Medical Press.*

AMBULATORY AUTOMATISM.—Automatism, in a physiological sense, may be defined as the performance of certain movements independently of the exercise of the will. Such movements may be extremely complex, and may, indeed, comprise the most ornate as well as the most simple motor performances. Were it not for this tendency to relegate the control of movements which have to be frequently repeated to subordinate nerve centers, life would indeed be a burden. If every step, if every act, required a distinct and separate effort of the will, no energy would be left available for the higher purposes of self-government, and the organism would lapse into the deplorable condition which results when a government endeavors to personally superintend, as well as to order the minor details of political existence. The will intervenes in the first instance to educate the subordinate nerve centers so that later on they may be enabled to perform the required movements without direct conscious control. There is no strict line of demarcation which separates healthy and economical automatism from the pathological. Its amount varies to an extraordinary degree in individuals, and even in the same individual under different circumstances. Some persons are peculiarly prone to acquire habits—a tendency which may be

viewed as a form of intellectual paresis. As age grows upon us the diminished cerebral activity takes refuge in a more automatic existence. Spontaneity of movement dies out to a greater or less extent, and gives place to habits of routine involving no great demand on the higher faculties. It is because the assimilation of new ideas, or adaptation to a fresh environment, disturbs the routine performance of functions that persons, as they get older, become proportionately disinclined to adopt them or to place themselves under conditions of existence which require a fresh adjustment and a consequently heavier demand on volition. Even in the normal individual this tendency often plays strange tricks. One is apt to perform the most inappropriate acts, and even to utter the most irrelevant remarks in response to stimuli which have excited habitual movements without the control of the reasoning faculties. Under ordinary circumstances such "absence of mind" is of but short duration, and the will soon reasserts itself with the return of consciousness. Instances are, however, on record of persons in whom this absent-mindedness is so intense and so prolonged that it becomes pathological.

Professor Charcot relates the case of a bank clerk, now aged forty-three, who on various occasions lost consciousness while on his rounds, and only awoke, as it were, hours or days after, without any recollection of his movements in the intervals. The attacks ultimately became so frequent that he placed himself under treatment, and gradually recovered. After some years, however, the malady recurred, and led to his arrest on a charge of misappropriation of money, and only the Professor's personal influence was efficacious in procuring his release. This curious condition offers many points of resemblance with somnambulism, which, while a perfect example of muscular automatism, differs from the case alluded to in that the intellectual faculties are practically in abeyance in the former, whereas in the latter it would seem as if *perception* alone were wanting. Being a purely subjective phenomenon, its investigation is naturally attended with much difficulty. Professor Charcot regards it as a variety of epilepsy—a sort of aggravated *petit mal*, itself a by no means uncommon though ill understood pathological condition.

Extraordinary as it may seem, we have not to go far to find its parallel in ourselves. Under the influence of a dominating train of thought or strong emotion perception is

practically suspended, although there may be no outward evidence of its temporary abrogation. One is justified in preserving a certain skepticism in these matters short of scientific demonstration, as otherwise one might involuntarily connive at the spread of a pseudo-malady to which Parisian *changeurs* seem peculiarly subject, the principal symptom of which is a liability to take the train for Belgium without being conscious of the risk that their sudden disappearance with the funds intrusted to their care may be misinterpreted. An automaton of this kind is certainly likely to prove a troublesome member of society, and unless they are enabled to foretell the advent of the attacks by the *aura*, it would be well to place them *volens volens* under suitable restraint. *Ibid.*

SIX CASES OF EMPYEMA TREATED BY RESECTION OF RIB AND THE INJECTION OF IODOFORM EMULSION; HEALING OF ALL THE CASES WITHIN SIXTEEN DAYS.—The following cases of empyema, of which we publish short notes by Mr. Blake, are certainly examples of rapid recovery after the operation for that disease. We bring them forward on account of the employment of the iodoform emulsion in each, but it is a question as to whether the emulsion worked so as to effect a quicker cure or whether equally satisfactory results might not have been obtained in the series by an early removal of the tube, similar care having been taken in other matters. It is not very unusual to get rapid healing in children after this operation, and we must suspend our opinion as to the value of the emulsion until a more prolonged trial has been made. It is to be regretted that no *post-mortem* record can be furnished in the fatal case. For the account of the cases we are indebted to Mr. William A. Blake, house surgeon.

I. (Under the care of Dr. Pasteur.) Ernest P., aged six years. Admitted on October 9th; discharged on November 7th; twenty-seven days in hospital after operation. His illness dated from September 29th to October 12th. Three quarters of an inch of the eighth rib resected, and about five ounces of pus evacuated, with shreds of purulent semi-organized lymph. The surfaces of the pleura were sharp-spooned, and four ounces of iodoform emulsion injected, of which three ounces were allowed to run out. The wound was dressed the same night, and every day for four days. 16th (fourth day): Tube shortened; temperature last night 102.8°. 17th: Temperature 103.2°.

after which it fell to normal. 23d (eleventh day): Tube left out. 26th: No communication between pleural cavity and external air; superficial wound dressed with red wash. Weight on admission, thirty-two pounds; on discharge, thirty-two and one quarter pounds.

II. (Under the care of Dr. Armand Semple.) Ellen S., aged two years. Admitted on November 8th; discharged on December 7th; stay after operation, twenty-two days. The illness dated from an accident fourteen days before admission. Diagnosis: pyo-pneumothorax. November 15th: Three quarters of an inch of the seventh rib resected, and ten ounces of sweet pus evacuated; details as in last operation. Wound dressed the same evening. Tube shortened on the third, fifth, and seventh days. 23d (ninth day): Tube left out; 26th: Wound healed; superficial granulating wound dressed with red wash.

III. (Under the care of Dr. Charlewood Turner.) Sarah H., aged ten years. Admitted on November 12th; discharged on December 12th; stay after operation, twenty-five days. The patient's illness dated from three weeks previous to admission. Diagnosis: pyo-pneumothorax (?). November 17th: Three quarters of an inch of the eighth rib excised, and eleven ounces of extremely fetid pus evacuated. Pleura treated in exactly the same way as before. 18th: Very little watery discharge; not offensive. 20th: Tube shortened on the fourth day. 24th: Tube left out on the eighth day. 30th: Wound healed on the fourteenth day. The temperature throughout was normal. Weight on admission, forty-nine pounds; on discharge, fifty-four pounds.

IV. (Also under the care of Dr. Turner.) Eliz. W., aged two years and a half. Admitted on November 19th; died on December 15th. Ill six weeks before admission. November 20th: Portion of the eighth rib on the left side resected, and three ounces of pus evacuated. Operation the same as before. Temperature for the next three days normal. 22d: Tube shortened. 23d: Temperature has reached 102.6°. 28th: The temperature has been down since last note. Tube left out on the ninth day. December 1st: Temperature still normal. Wound healed on the twelfth day. 2d: Temperature rose suddenly to 102.8°. Well-marked signs of broncho-pneumonia in left lung. The child gradually sank and died.

V. (Under the care of Dr. Pasteur.) Mary A. D., aged a year and nine months. Admitted on November 28th; in hospital at

present time. November 29th: Rib resected, and six ounces of pus let out; details as before; pus very fetid. 30th: Watery and almost odorless discharge. The temperature came down to normal and remained so. December 6th: The tube was shortened on the third and eighth days. 8th: Tube left out on the tenth day. 12th: Wound healed on the fourteenth day. The child is gaining weight slowly.

VI. (Also under the care of Dr. Pasteur.) A. B., aged five years and eleven months. Admitted on November 20th; discharged on December 21st; stay in hospital, twenty-nine days. November 22d: Portion of seventh rib resected, and nine ounces of pus evacuated; details the same. The temperature came down to normal after operation and remained so until the 30th, when for a week it fluctuated between 98° and 103°, and then returned to normal; this rise was thought to be due to iodoform. 26th: Tube shortened on the eighth day. 30th: Tube left out on the ninth day. December 3d: Wound healed on the twelfth day.

Remarks by Mr. Blake: For permission to publish these cases I am indebted to the kindness of the medical staff of the above hospital. These are the last six empyemata that have been treated in the hospital, and are not selected cases. All were treated in precisely the same manner, viz., a portion of rib was excised, the fluid pus allowed to run out, the flaky semi-organized lymph removed with a sharp spoon, and finally four ounces of iodoform emulsion injected into the pleural cavity, three ounces of which were allowed to run out. That the iodoform emulsion materially hastened the healing process there can be little doubt, for in all cases except one the drainage-tube was left out on the ninth day (on the twelfth in the exceptional case), the wound healing—that is, the communication between the pleural cavity and the external air being shut off—from the twelfth to the sixteenth day.—*London Lancet*.

EXCISION OF BONE TO PROMOTE HEALING OF SOFT PARTS: GASTRIC SYMPTOMS RELIEVED BY ABDOMINAL SECTION: LIGATURE OF LINGUAL ARTERY.—At a recent meeting of the London Medical Society, Professor Annandale (Edinburgh) read a paper on the excision of bone in order to promote the healing of certain wounds or ulcers, or to relieve contraction resulting in connection with this process. He remarked that this proceeding was not new, and that his first experience of it was in the practice of the late Mr. Syme more than twenty-five years

ago, since which time he had himself operated upon several cases. For conciseness he considered the subject under the following four heads: (1) The removal of a portion of bone, not including its entire thickness. (2) The excision of a portion of the entire thickness of a bone, or, as in the case of the fore-arm and leg, of two bones. (3) The partial or complete excision of a joint when the sore or contraction involved the soft parts in its neighborhood. (4) The excision of a portion of the entire thickness of one or other of the bones of the fore-arm or leg, in order to allow the proper approximation of the ends of its companion bone, which had suffered some loss of substance. In regard to this fourth head, it was observed that, although scarcely included in the title of the paper, it was nearly allied to it. Illustrative cases occurring in the author's practice were described, and recorded cases by other surgeons referred to. One of the most interesting of these was one in which Mr. Annandale had removed two inches and a half of the shafts of the tibia and fibula in order to promote contraction and healing of a large sore upon the leg. The case was perfectly successful. In conclusion, he stated that, as a primary operation in cases of injury, this procedure was not likely to be useful except in rare cases, as it was impossible in the first instance to be certain of the exact amount of the loss of the soft parts, and he expressed the hope that the experience of the operations referred to would encourage surgeons to make use of the principle in suitable cases. Sir William MacCormac thanked Professor Annandale for his practical and interesting record. In the first case, he asked whether the destruction of soft parts was so great as not to be amenable to some measure less severe than excision. Could not transplantation of skin from the opposite limb have been tried? The procedure of removal of bone had been devised to bring nerve ends together. To remedy faulty union of a second bone, he thought it a good and new idea to excise a bit of sound bone. Mr. Bryant remarked on the novelty of removing bone in order to permit separated soft tissues to approach each other. His experience in this direction was small; he had once, in a case of injury to the heel with damage to the os calcis, removed a considerable amount of bone and brought the soft parts together, but this was done without applying any definite principle. He could recall two or three cases where this method might have been applied. Mr. Rose had had two cases

of fracture near the lower tibial epiphysis under his care, followed by arrest of growth and gradual malposition of foot, and he had excised two inches of the fibula and brought the foot into position; but this was done, not to secure union of the bone but to rectify malposition. In the first instance he took away three quarters of an inch of bone, and in the second one inch. Mr. Pitts recollected seeing two cases of disease of the os calcis under Mr. Sidney Jones, where the soft parts were dissected off the margins of the bone, and the margins removed in order to approximate the soft parts and secure more rapid healing. Professor Annandale, in reply, said that he suspected the number of cases of primary operation after injury requiring this treatment would be very few. He had operated on two cases on the same principle as Mr. Rose had done; but it was the tibia which, as the result of inflammation, had grown more than the fibula. He cut across the latter bone and put the foot straight; this produced a gap between the two cut ends of the fibula, which was afterward filled up with newly formed bone. *Ibid.*

ON THE ACTION OF CERTAIN DRUGS ON THE PREGNANT UTERUS.—In the number of the British Medical Journal for November 24th, a correspondent asks, if, in a case of suspected abortion, "he should prescribe a mixture containing iron or *any other emmenagogue which causes abortion* (the italics are mine), how would he stand if accused of intentionally procuring abortion?" And, again, in the case of a married woman who has "missed one menstrual period and is complaining of 'neuralgia,' how is the practitioner to act in similar obscure cases? Is he justified in giving an emmenagogue?" As I have for more than twenty years carefully watched the action of medicines on the utero-ovarian system, and especially with reference to their effects on the menstrual function, my opportunities for observation having been exceptionally great, and as I take much interest in the question, I venture briefly to make a few remarks on the subject, for I think your correspondent and numberless other practitioners are laboring under false impression as to the power of drugs in such cases as he refers to.

It is right that I should, in the first instance, say that I have never made any experiments on pregnant women, and that the opinions I now hold are based, first, on the fact that, in the treatment of certain diseases and affections in which I felt myself called on to administer to pregnant women drugs supposed to have

the power of inducing abortion, I never observed them to have any such effect; and, secondly, that having administered the so-called emmenagogues to women who were not pregnant, in almost every possible form, my belief in their value has been so shaken that I have grave doubts as to their efficacy, except in cases where the amenorrhea depends on the presence of some condition or affection such as anemia, incipient phthisis, etc., which being removed or cured, menstruation recurs.

I will relate a case which made a great impression on me at the time, and has materially influenced my practice ever since. About fifteen years ago I was asked to see a lady threatened with abortion at about the tenth week of pregnancy. She had been married two years, and during that time had aborted on three previous occasions. I found that she had lost some blood, which continued to come away continuously, but there were no pains; and, on examining her, the os uteri proved to be patulous. She was very nervous, having had sharp hemorrhage on a previous occasion. Taking into consideration her history in connection with her present state, I came to the conclusion that she would again abort, probably with hemorrhage; and I deemed that the sooner the ovum was expelled the less risk there would be of the occurrence of a dangerous loss. With the view, therefore, of lessening the risk of hemorrhage and exciting the uterus to expel the ovum, I put her on ergot. The result was most satisfactory, but not what books would have led a student to suppose. No uterine action followed on the administration of the ergot, but the hemorrhage gradually lessened. I kept this patient in bed for many weeks, and in due time she gave birth to a son, who still lives and is in robust health.

From that time on I have treated similar cases on the same principle, that is, the patients threatened with abortion, hemorrhage being present, but uterine action, indicated by the occurrence of pains, not having been excited, I administer ergot; these patients are frequently plethoric, with relaxed muscular tissue, and I think it probable that in them the ergot excites a tonic contraction of the muscular tissue of the uterus, which by lessening the blood supply checks the hemorrhage. In some the ergot excited uterine action, but in all these I had little hope of averting abortion, and believed that it was inevitable. In many ergot seemed to produce no effect at all, and my belief is that ergot will rarely excite uterine action in cases of threatened abortion, unless the ovum is already blighted and virtually a foreign body. If, therefore, for any reason the administration of ergot was deemed

necessary in the case of a pregnant woman, I should not hesitate to give it. I may add that for many years I was in the habit of administering ergot for several days before the expected date of parturition to patients liable to *post-partum* hemorrhage, with the view of anticipating its occurrence, with very satisfactory results. In no single case did labor set in earlier than was expected, in none did the child suffer in any way, while in two or three cases the occurrence of labor seemed to have been actually delayed by several days. Iron and quinine I have for several years administered as freely and in as large doses to pregnant women as to any other patients, with perfect safety; in fact, I much doubt whether the ordinary medicines given in ordinary doses have any effect on the retro-ovarian system, whether it be in the case of pregnant women, or taken during the continuance of the menstrual flow; but as I have recently, in a paper published in the December number of the *Dublin Journal of Medical Science*, an abstract of which appeared in the *Journal* for December 1st, discussed this part of the subject at some length, I abstain from referring further to it now.

I must, however, express my surprise at "Omega's" hesitating to prescribe iron in case of suppression of the menses, and at his classing it with "emmenagogues which cause abortion." Personally, I know of no emmenagogue which will cause abortion; ergot, quinine, and strychnine, in ordinary medicinal doses, I am satisfied, will not do so. Savin and rue, etc., I have never ventured to give to pregnant women, because I believed them to be unsafe drugs to administer in such cases; but iron is perfectly innocuous, and its being classed by any practitioner with "emmenagogues which cause abortion," shows how little consideration has been given to the action of drugs on the utero-ovarian system by medical men.

I can, in conclusion, without hesitation, say that in cases similar to those referred to by "Omega," any of the ordinary tonics, including quinine and strychnine, in ordinary doses, may be safely administered, assuming of course that the patient's general health is good. None of them will induce abortion, but neither will any of them have any direct effect either in inducing or retarding the menstrual flow, and perfect general health is not incompatible with even the prolonged suppression of menstruation.—*Dr. L. Atthill, British Medical Journal.*

ON LEAD-POISONING FROM SERVICE PIPES, IN RELATION TO STERILITY AND ABORTION — The following cases are of interest, inasmuch as they suggest, if nothing more, a possible

danger arising from the supply of water through leaden piping for domestic purposes.

I. Mrs. T., aged about thirty-two years, was confined in 1882. Since then she has had progressive ill-health, with constipation, digestive disturbances, frequent colic, rheumatic pains, and irregular menstruation, with now and then severe menstrual hemorrhage. After cessation of menses for eight weeks an abortion occurred on March 17, 1884. After cessation of menses for seven weeks, another abortion took place on September 10, 1884.

Colic continued to be frequent, and severe constipation remained obstinate, and recurrent attacks of metrorrhagia became alarming. I had for a long time been of opinion that the water-supply, which came through lead piping of some length, was the cause of all the foregoing symptoms, and in the early part of 1887, my patient having been confined to bed for some months, iron piping was substituted. After this there was only one attack of colic, and no severe hemorrhage. The bowels became regular, and menstruation became normal for a time. Pregnancy ensued, and my patient was confined of a healthy child on March 2, 1888. Since then she has remained in good health.

II. Mrs. C., aged about thirty years, had one child, some seven years ago, in 1882. She came under my care in 1885, suffering from constipation, indigestion, and colic. She has irregular and frequently profuse menstruation. She aborted, after suspecting pregnancy for eight weeks, on January 6, 1886. She has a blue line on the gums. I ascribed her abortion and previous illness to lead piping, and these were removed and iron pipes substituted. Colic became less severe, and disappeared; the bowels became regular; menstruation became normal; then pregnancy ensued. On October 22, 1887, she was confined of a healthy child, and has since remained in good health. In the same house the servant suffered from rheumatic pains, colic, and constipation, until the removal of the lead piping, after which she regained her wonted health.

III. Mrs. F., aged about thirty years, has two children. The last was born on September 7, 1884. After this her health became seriously impaired; she had severe digestive disturbances, rheumatic pains in the limbs and loins, constipation, colic, and very irregular menstruation. Her life became a burden to her, no treatment being of any avail. I told her husband that I believed all her symptoms were due to the water-supply, but he ridiculed the idea. I referred him to Cases I and II. Even after receiving their evidence, his skepticism remained, but he removed the lead

piping and substituted iron. The result was as remarkable as in Cases I and II; all the symptoms disappeared and menstruation became regular. Then pregnancy ensued, and on May 11, 1887, my patient was delivered of a healthy child, and has since remained in good health.

I do not record these cases in a dogmatic spirit, nor do I aspire to scientific accuracy in my deductions from them; but there can be little doubt that in Cases I and II the cause of abortion and hemorrhage was water contamination by lead, and in Case III one may reasonably suspect lead as being the cause of all the symptoms.

It has fallen to my lot to observe many cases of plumbism, and its relation to sterility and abortion only touches the very fringe of a vast subject. The influence of lead on the nervous, vascular, muscular, lymphatic, and digestive systems merits greater consideration than has hitherto been devoted to it.

To suppose that plumbism means only wrist-drop and paralysis of the extensors of the fore-arms seems to me to be illogical. I believe that, in plumbism, neuritis is not confined to any particular set of nerves. Is not lead colic due to paralysis of the nerves regulating the muscular coat of the intestines? What is the meaning, in cases of lead-poisoning, of the tense pulse, the liability to epileptiform seizure, to cerebral and other hemorrhages, to gout and uric acid, and to albuminuria and rheumatic pains? Surely these point to both nervous, vascular, and metabolic derangements which open up a wide field of inquiry for those who are interested in our food and water-supply and in public health generally.

This paper is written only to suggest grave possibilities to those who at present barely recognize a serious source of danger, and although I personally am satisfied of the far-reaching and lethal influences of lead in relation to many conditions not generally regarded as having any connection with it, yet I would prefer that those with more opportunities at their disposal than I possess would follow out a line of investigation which I have merely indicated. I am satisfied that they will find a fertile field for research.—*Dr. Alfred Swann, British Medical Journal.*

CHROMIDROSIS.—Dr. Arthur Wynne Foot made a communication to the Royal Academy of Medicine in Ireland on chromidrosis, in which he reviewed the present position of the subject. Tracing the history of the disease from the first case recorded by Dr. Yonge, of Plymouth, in 1709, up to the present year (1888), he found that there were forty-six ad

mittedly genuine cases on record—cases which had passed repeatedly through the crucible of criticism, and to which no exception could be taken. Of these forty-six cases, six had occurred in men and forty in women—for the most part young and unmarried. That so small a number as forty-six cases should have been reported in the one hundred and eighty years since Dr. Yonge first drew attention to it, Dr. Foot considers to be a proof of the rarity of its occurrence. As recently as the year 1861 the Medical Society of the Hospitals of Paris gave an open verdict on the subject, notwithstanding the strong pleading of M. Hardy in its favor; and in the same year the Imperial Academy of Medicine declined to allow De Méricourt's essay on chromidrosis to be published in their memoirs, on the ground that the authenticity of the cases was doubtful, although the committee which they had appointed to report on it recommended it merely for publication, without asking for the expression of any opinion on its merits. On April 4, 1882, a committee of the Clinical Society of London reported "that chromidrosis has an undoubted existence as a genuine affection." He was not inclined to follow Féréal in substituting the name *chromocrinia* for chromidrosis; for, if the views of Meissner and Unna were correct, that the coil of the sweat gland secretes fat and the end of the duct sweat, disorder of the coil glands would account for all the phenomena. He was in favor of the theory that the pigment was due to the oxidation of indican eliminated by the cutaneous glands; its preference for the face he explained by the free exposure of that area to the great oxidizing influences of air, light, and heat. Some ferment also might operate in effecting the conversion of soluble colorless indican into indigo-blue or bronze. The possibility of a bacterial origin was, however, not to be overlooked, as the source of the color in "blue milk" was often the bacterium *cyanogens*, and in red sweating the bacterium *prodigiosum*. The indican, he considered, was derived from the absorption from the intestinal canal of small quantities of indol. The frequency of constipation in chromidrosis, the sudden disappearance of the color after purgation, its diminution after regulation of the bowels, and the general aversion to animal food these cases exhibit, were, he considered, facts which made in the direction of his view. The proportion of indican in the urine increases *pari passu* with the amount of exudation on the face, and *vice versa*. Hoffman had detected indigo in the bluish-black exudation, and after reducing the pigment to indigo-white it was seen to regain its color by exposure to air. Dr. Hayes re-

ferred to the case of a lady whom he had known for nine years, and who for the last five years had had a deposit of black pigment round both eyes, extending into the eyebrows, enveloping the upper lids and the same distance of the lower, presenting all the appearances of a well-marked case of chromidrosis. At present the pigment could be easily removed, and he had seen it re-form. The lady was of a highly nervous temperament, and had suffered from hysteria, and was the subject of arrested phthisis. Dr. Boyd said, some years ago a young lady was brought under his notice. She was dark and good looking, and it struck him at the outset that she wanted to heighten the appearance of her eyes by means of some pigment applied to the lids, but she denied doing any thing of the kind. He wiped off some of the pigment with a towel, but could not remove the whole of it. The family soon seemed to recognize the pigmentation as her normal state, and paid no attention to it. The lady got married, and he afterward saw her in this country. The pigmentation had considerably disappeared, but a portion still remained on the eyelids. Besides suffering from anemia, the lady suffered also from obstinate constipation. He had no doubt the case was one of chromidrosis. Dr. Purser said, why the sweat-glands should be affected in the face and in no other part of the body seemed anomalous, as not being a part of the body where these glands were very highly developed or prone to sweat; on the contrary, the sweat glands were rather small and scanty, and this was not a part which was devoid of sebaceous glands. It was much more probable that it was a bacterial affection in which there were chromogenic bacteria, and the bacteria lying there simply acted on the superficial epidermis. Dr. Walter Smith, accepting chromidrosis as a true pathological occurrence, regarded the question of its rarity as of secondary importance, and that the important question was the identity of the indigo. In the terminology of the subject it was a pity that indican should be used in reference to the urine. It was not the same as the substance that occurred in plants—it was not identical with the indican of the indigo plant.—*London Lancet*.

**CARDIAC VALVULAR DISEASE.**—At a recent meeting of the Glasgow Medico Chirurgical Society, Dr. Middleton (London Medical Press) read a paper on this topic. It was an analysis of a series of cases observed at the Royal Infirmary Dispensary. Excluding all cases of anemia and chorea with murmur, and also all cases of cardiac affection without murmur, the series numbered 139, or at the rate of about 1

in 40 new cases. Some interesting facts were brought out in regard to the ages and sexes of the patients, up to the age of forty there being more females than males, while after forty the males greatly preponderated. The statistics gave 64 per cent with a rheumatic history, bearing out the general opinion as to rheumatism being the most important of the factors in the etiology of valvular lesion. Dr. Middleton further insisted, however, on the importance of strain as a factor, and in support of this view he referred to the greater frequency of these affections in men after forty, and in particular to the excessive proportion of cases of aortic obstruction and regurgitation in males, the numbers being 32 in males as against 9 in females. The paper also dealt with the incidence of disease on the various valves, with the absence of symptoms in many cases, and with treatment, but a considerable space was devoted to the question of prognosis, and especially to the question of prognosis in pregnant women. Dr. Middleton's observations corroborated the views long entertained by Professor Gairdner, that too gloomy a view had at one time been taken of these cases, and especially of cases of mitral stenosis.

Dr Campbell Black said, that in anticipation of the observations of Professor Gairdner, and other gentlemen of experience present, he was disappointed that Dr. Middleton, in his valuable paper, made no reference to the disappearance of cardiac *bruits*. He referred to a case that was under his care more than ten years ago (*British Medical Journal*, Feb. 1884), in which a double aortic bruit existed, and which had disappeared, leaving no trace of disease, cardiac or otherwise. The case was also seen by Professor Simpson, who confirmed the diagnosis. He referred to the paper read by Dr. M. A. Boyd, of Dublin, read before the Royal Academy of Medicine in Ireland, on the 25th ult., and to similar cases which occurred in the practice of this gentleman.

Professor Gairdner remarked that he had long taught that mitral disease was much less serious than other valvular disease of the heart. He considered that the late Dr. Angus McDonald attached too grave a prognostic significance to mitral disease as affecting pregnancy. This was shown in a case of his own referred to by Dr. Middleton, in which mitral stenosis was diagnosed more than twenty years ago. The patient had gone safely through seven pregnancies since then, and was now in her ordinary state of health. He had never seen such a case as Dr. Black's, and he thought such cases must be extremely rare.

Dr. Gemmell referred to a case in which what was believed to be a double aortic bruit

had disappeared. He was now inclined to think that there was an error in diagnosis, and that the case was one of pericarditis.

**TREATMENT OF HEMIPLEGIA.**—We have at the present time only a symptomatic treatment of the paralysis pointed out to us, and it is a question whether we can in any way further the curative process. Our curative ability is very small; we can accomplish very little in such cases, although with certain therapeutic procedures a distinct improvement is perceptible, and in many cases something is accomplished by means of some remedy that in others has no result whatever. Baths come first under consideration. The so-called animal baths were employed at the beginning of the century, and down to the "forties," and even at the present time the folly is perpetrated by country people. In these baths the paralyzed arm or paralyzed leg was placed in the cavity of the body of a calf just killed. Well, for such like things I have no criticism. Of the different baths, the mineral ones do not come to any extent into consideration. Above all you must avoid all too irritating or too hot baths, you may easily by these means rather injure than better your patient; you should not, therefore, send hemiplegics to Weisbaden, Wildbad-Gastein, or Wildbad in Würtemberg; from the sulphur baths also to which patients are sent, year in year out, you have not much to promise. Most of all, we see a good result from the so-called indifferent thermal baths. You will, therefore, send such cases to Krapna-Teplitz, Bohemian Töplitz, Tüffer, or Ragaz. I must in any case remark to you that you often send them for years without seeing the slightest improvement. You may promise a better result than from thermal waters from an intelligently carried out cold-water cure. You will naturally understand that what I have said before is true here, that excitatory procedures effect the very opposite of what is aimed at. Temperatures of 10° or 12° C. are too low, 24° C. should be the commencement, or if no improvement is visible you may go down to 20° or 15° C. No forced douching should be employed, at most a fan-shaped douche may be used; you should content yourself with drying off and friction, but I can not sufficiently emphasize to avoid any thing exciting. Patients frequently come to me with the complaint that they can move the arm or leg much less freely than they could since they had been in a cold-water bath, and I am convinced that the disease has become worse through unsuitable treatment. Of internal remedies there is scarcely one that has not been tried, and it is specially—I know not

why—the iodide of potassium and iodide of sodium already mentioned that have attained the most honorable place. A special action has further been attributed to nux vomica; an increase of the reflex movements was often found after the employment of this drug, and this was looked upon as an increase of power of movement generally; this medicine has now fallen completely into disuse. Some improvement, and especially in cases in which atrophy of the muscles has taken place, can be promised by the use of massage skillfully performed, retrogression of the contractions is frequently observed. If this procedure is carried out roughly, the evil is not unfrequently made worse, it must therefore be done by the physician or by a skilled assistant. The most important of all means employed in the treatment of paralysis is indisputably electricity, and for more than a century electricity has been employed in the service of medicine. Frictional electricity is now completely abandoned, and we have already learned the ineffectiveness of the faradaic current. Duchenne rightly recognized that in paralysis nothing could be accomplished with the induced current; when contractions are present the evil may be aggravated, and it is only in mobile paralysis that the current can do any thing; in atrophy of the muscles also local faradization is successfully employed. More power must be adjudged to the galvanic current. When Remak first introduced the galvanic current into medicine great hopes were built upon it, which, however, have not been realized. I have galvanized hemiplegics for many years, but, and most observers are in agreement on the point, I have not perceived any improvement. Nevertheless one always comes back to it, because one has seen contraction that has lasted for years resolved by the constant current. The technique of galvanization must be studied. Generally the anode is placed over the skull, the cathode on the paralyzed muscles, or the anode on the neck over the medulla, the cathode on the paralyzed extremity. When we take all these means together we must confess that in the case of inveterate paralysis we can accomplish practically nothing, and if we see now and then some improvement, it seems least of all to be brought about by artificial means. We are at the present day powerless as regards paralysis as well as nearly all diseases of the brain. I am in the habit of letting patients practice passive movements. I make passive movements over the paralyzed extremities, and then let the patients imitate them: if these are repeated daily for weeks together they succeed in obtaining some movement. Occasionally I meet with some success; in what way

this is obtained is dark, however; it is possible that the impulse of the will acting by another route has given rise to the possibility of movements in the same way as has been observed when an aphasia has lasted for months, the power of speech has returned, in consequence of an apoplectic attack. It is related of a well-known professor of national economy that after an apoplectic attack he became quite aphasic. In six months' time he was able to recommence his lectures; the autopsy revealed complete destruction of Broca's speech center.—*Dr. H. Nothnagle, Medical Press and Circular.*

**IGNIPUNCTURE OF THE TONSILS.**—Dr. Wilhelm Roth, of Fluntern, finds that in order to reduce the size of the tonsils without risk of troublesome hemorrhage, which is not uncommon, especially in young subjects, the best plan is to employ ignipuncture, as has been recommended by Krishaber, and more recently by Verneuil. The tonsils and neighboring parts are first brushed over with a ten to twenty-per cent solution of cocaine. The finest point of the thermo-cautery, heated to redness, is then inserted to a depth of about five millimeters in three or four spots a few millimeters apart from one another on the tonsils. The instrument is not allowed to remain more than one or two seconds in the tissue. The whole operation, including both tonsils, can be performed in a very few minutes without any bleeding, and with scarcely any pain. It must be repeated four or five times at intervals of two or three days, and this is usually sufficient to cause the tonsils to return to their ordinary condition.—*London Lancet.*

**SPONTANEOUS AND TRAUMATIC TETANUS.**—At the Académie de Médecine M. Nocard spoke on the nature of tetanus, spontaneous and traumatic. He thought that the influence of cold in the production of the affection was incontestable, but he believed also that tetanus could be inoculated. As to the location of the virus no doubt existed on it as the nervous centers were the seat, as in the case of rabies. The period of incubation in traumatic tetanus was variable, but M. Verneuil cited several cases in which the malady appeared on the seventh day after the traumatism. M. Leblanc said that he could not accept the opinion of M. Verneuil, who accused the horse of being the cause of tetanus in man. As long as the microbe was not isolated, cultivated, and inoculated, he would not believe in the infectious nature of the disease. If the reverse were the case antiseptics would have given better results.—*London Medical Press.*

# The American Practitioner and News

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D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } - - - Editors.

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## COMMENCEMENT EXERCISES OF THE UNIVERSITY OF LOUISVILLE.

The Medical Department of the University of Louisville celebrated its fifty-second annual Commencement in Macauley's Theater on the evening of the 1st of March. The charge to the graduates, given by the Hon. James S. Pirtle, President of the Board of Trustees, was pertinent to the occasion. The class valedictory was delivered by R. E. Sievers, M. D., of Louisville, and was of better quality than is usual in such literature. We make room elsewhere for a few extracts from it. The faculty valedictory was made by Prof. Turner Anderson, and will well repay reading. Some of the views of this very popular teacher will not be generally accepted by the profession, but they are strikingly put, and can not fail to stimulate thought.

The degree was conferred on one hundred and twenty-nine candidates, the largest number ever graduated by the institution at one time. The following is a list of their names:

Edgar O. Allhands, Indiana.  
W. E. Adams, Kentucky.  
W. Thornton Adams, Kentucky.  
Birge D. Alexander, Tennessee.  
James B. Bullitt, Kentucky.  
David M. Buley, Indiana.  
David C. Bowen, Kentucky.

Robert E. L. Burford, Kentucky.  
John W. Bean, Alabama.  
Dillard A. Burget, Indiana.  
Lacy K. Bobo, Kentucky.  
John F. Buntton, Kentucky.  
James S. Chenoweth, Kentucky.  
Hal B. Canine, Kentucky.  
Charles C. Coleman, Kentucky.  
Charles C. Copeland, Indiana.  
John B. Cassell, Kentucky.  
John N. D. Cloud, M. D., Florida.  
Frank H. Clarke, M. D., Kentucky.  
Paul M. Donigian, Turkey.  
Achilles E. Davis, Kentucky.  
Robert L. Douglas, Texas.  
William H. Deitz, West Virginia.  
Thomas Doran, Kentucky.  
Frank Davies, Kentucky.  
Benjamin S. Elliott, Texas.  
Lee J. Eads, Kentucky.  
Edward M. Eakle, Kentucky.  
Simon Flexner, Kentucky.  
James W. Ferguson, Kentucky.  
John H. Farris, Missouri.  
Waller O. Green, Kentucky.  
James T. Glass, Texas.  
Dumont Garey, Indiana.  
John F. Gullledge, Kentucky.  
Philip C. Giltner, Kentucky.  
Charles I. Groves, Kentucky.  
Hugh Goodwin, Kentucky.  
Ernest M. Gallion, Tennessee.  
Allen D. Gilmer, Missouri.  
Samuel M. Green, Illinois.  
James T. Hicks, Texas.  
John L. Howard, Kentucky.  
Steven H. Hurst, Indiana.  
B. Logan Holmes, Kentucky.  
James W. Hill, jr., Kentucky.  
Cash L. Herren, Kentucky.  
Milton H. Hollcroft, Indiana.  
Charles G. Herndon, Kentucky.  
Carl E. Hostetter, Kentucky.  
William C. Hunt, Kentucky.  
Everett V. Hamilton, Texas.  
Thomas Wilbur Hathaway, Wisconsin.  
John W. Hays, Kentucky.  
Roberts R. Hourigan, Kentucky.  
William A. Haynes, Tennessee.  
Josephus Hooper, Kentucky.  
Lafayette F. Harmon, Dakota.  
Elam P. Horton, Texas.  
James T. Holloway, Mississippi.  
John William Hudson, M. D., Texas.  
George D. Jeffers, West Virginia.  
J. Thomas Kime, Indiana.  
William T. Logsdon, Indiana.  
John L. Lusk, Kentucky.  
Adolph J. Lieber, Kentucky.  
Adam Mackey, Illinois.  
Ponciano Munoz, Central America.  
Horatio S. Morris, Virginia.  
Joshua W. Meshew, Kentucky.  
George W. Moore, Kentucky.  
Robert S. Mason, Indiana.  
Alban Moorman, Kentucky.  
James T. Morris, West Virginia.  
John H. Masterson, Alabama.  
Alver A. Masterson, Alabama.  
Joseph A. H. Miller, Kentucky.  
John P. Mathews, Texas.  
William H. Martin, Kentucky.

Andrew B. Marcum, Kentucky.  
 Tinsley J. McMurry, Kentucky.  
 John A. McEachern, Alabama.  
 Delle H. McMasters, Kentucky.  
 George H. McNeer, Kentucky.  
 D. Brougham McGee, Texas.  
 John F. McGee, Texas.  
 Sherwood W. McClure, Kentucky.  
 Curran Pope, Kentucky.  
 Eugene B. Pendleton, Kentucky.  
 Henry Sanford Pierce, Kentucky.  
 Arthur H. Robbins, Kentucky.  
 Leslie L. Robertson, Kentucky.  
 William L. Rodman, M. D., Kentucky.  
 Junius A. Rawlings, Kentucky.  
 James F. Rinehart, Kentucky.  
 William W. Ragsdale, Texas.  
 Robert R. Rhodes, Arkansas.  
 George W. Reaburn, West Virginia.  
 George Henry Rice, Texas.  
 John Lettett Robbins, Kentucky.  
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 John W. Smith, Texas.  
 Robert E. Sievers, Kentucky.  
 James H. Spencer, Arkansas.  
 James E. Shannon, Tennessee.  
 Ulysses G. Senour, Kentucky.  
 John H. Stigall, Kentucky.  
 J. Clemilla Sellers, Texas.  
 Henry O. Stacy, Texas.  
 Egbert S. Smith, Kentucky.  
 Archibald A. Strange, Tennessee.  
 Ziba H. Trout, Kentucky.  
 Willey F. Truitt, Kentucky.  
 Claude W. Trapp, Kentucky.  
 William E. Turner, Kentucky.  
 William O. Taylor, Tennessee.  
 Thomas G. Turner, Kentucky.  
 John S. Turner, Kentucky.  
 Francis A. Taylor, Kentucky.  
 William L. Vories, Kentucky.  
 Charles W. Vimont, Kentucky.  
 J. Harry Wilson, Kentucky.  
 Isaiah S. Wesley, Kentucky.  
 William W. White, Kentucky.  
 William D. Wyatt, Kentucky.  
 Eugene A. Whittington, Kentucky.  
 Joshua T. Wesley, Kentucky.  
 Willie P. Yongue, M. D., Kentucky.  
 John B. Winn, Texas.

#### DR. SIEVERS' ADDRESS.

*Graduates:* In this our first triumph—the reception of our sacred commission—it seems not unfitting that we should define our position and set forth our principles.

Medicine is a composite science. Standing on the border land between things tangible and things invisible, it draws its spirit from both realms, and, being in touch at some point with all other sciences, it is the epitome of human knowledge. A broad science, a profound philosophy, it deals with what is of the most fervent interest to the individual—the riddle of the material and immaterial, the mystery of “be-

ing and ceasing to be.” Born of the necessities of humanity, founded upon the crowning impulse of benevolence and civilization, its object to comfort and to save, it has long been classed as one of the three learned professions. And, dealing with health and life, it is of the three callings at once the noblest and the most humane.

When unselfish in his devotion to the interests of humanity and of his profession, and giving no thought to himself in the performance of his duty, the physician is surely the benefactor of his race. Into the sacred precincts of the family circle, under confidence more binding than friendship, in pestilence more deadly than battle, he pursues his lofty mission. With skilled and gentle hands, often without fee or reward, he binds up the wounds of poverty and gives solace to the pangs of the degraded. While “tired Nature’s sweet restorer” visits the lids of others, he in darkness and in storm pursues his weary way to the chamber of the sick that he may supply their needs and heal their diseases.

It is the physician who presides at the incoming of young life, and who hears its groan when death closes the scene. None can doubt the importance of his trust or question the sanctity of his mission.

The idea that the profound study of this, the most enlightened of professions, tends to beget skepticism in its votaries is a fallacy as erroneous as it is popular. The very desire to relieve human suffering, which is the crowning glory of the physician, proves that such a charge is without foundation. The physician is necessarily acquainted with the ills that human flesh is heir to. Birth, death, the devotion of faith, the anguish of despair, are phases of life daily open to his view, and their simple contemplation, while it points to a sense of common brotherhood, can not fail to excite the higher impulses of his nature and kindle within him the very broadest spirit of humanity.

The physician treads where no other feet but those of kindred tread. He thus becomes the auditor and spectator where no stranger ever looks or listens. Human nature is bared to his view. The secrets of conscience, the devotion of love, all that exalts, no less than all that

debases, are all bared to his eyes. Hard and unthinking indeed must he be if such scenes make no enduring impression, excite no comprehensive sympathy.

Medicine is not an exact science, nor in the nature of things can it ever be; yet it has been no laggard in the procession of progress. It has invented new instruments and appliances that have revolutionized diagnosis and simplified the treatment of disease, while vegetable and mineral substances have in new combinations been made to yield new and potent remedies. The old-time trocar and canula have made way for the aspirator. Cocaine, chloroform, and ether have exorcised the demon of physical pain, and opened up a new era in the annals of surgery. Under the teachings of Lister joints and serous cavities are opened, and the domain of the sacred peritoneum itself invaded with impunity. Internal passages and organs are illuminated and made patent to the physician's eye. With the sphygmograph he weighs the pulse in a balance, and makes it write its own history. The microscope he daily uses; while electricity does his bidding. And yet, with all its countless achievements, our profession is but in its infancy. Physiology has not yet given up all her secrets; the great domains of pathological anatomy and preventive medicine have scarcely been entered upon, while therapeutics may be said to be yet in its early youth.

#### PROTECTION FROM IRREGULAR PRACTITIONERS.

Correspondents in the English medical journals are again raising the hopeless cry for protection against competition from irregular practitioners. It seems that any body at all can practice medicine in the British Isles; the only difference in legal standing between the physician who has, after six or seven years' arduous study, received the diploma of the Royal College of Physicians and the man who has been made a doctor by the tinsmith and sign-painter, is that the latter is restrained by the law from suing for his fees, while the former is restrained to the same extent from collect-

ing his fees at law by the traditions of his guild.

According to a recent writer in the London Lancet, there are plenty of doctors in England who are in the habit of drumming, or "touting," as they call it on that side of the water, for obstetric cases at from a dollar and a quarter to two dollars a case.

The contagion, it seems, has even reached Louisville. Not long since the statement was made by a reputable physician, at one of our medical societies, that a case of midwifery for which he had been engaged had been offered attendance by a professor in one of our medical colleges for five dollars. The name of the professor was withheld; but whether he ever becomes known to the public or not, it is to be hoped that his practice will speedily attain such dimensions as will relieve him from the necessity of "touting" for business at such prices.

#### SOME OBSCURE POINTS IN EMBRYOLOGY.

It would not be easy to find in the domains of physiology a subject requiring more extensive study and larger exercise of the imagination to understand than the process of development of the fetal membranes. Many points in this department of embryology have not yet been satisfactorily elucidated, and even some that have are set forth with such obscurity of pictorial illustration and verbal description, even in our best works, that the great majority of medical students and physicians give up in despair the task of mastering them, and remain in a state of ignorance as well as indifference regarding them. As one feature in point, it is almost impossible to decide whether the mesoblast grows into a complete sac fitting in between the two bladder-like sacs formed by the epiblast and hypoblast, or whether it stops at the constriction which marks the beginning of the separation of the yolk sac or umbilical vesicle from the embryo. It is much easier to conceive the three plates as each forming a complete sac and entering into the formation of the wall of the yolk sac.

Another matter that is largely lost sight of in most treatises is the method of formation of the amnion. From a perusal of a majority of these works, every part of the amnion is lost sight of except the fold or tuck that bends back over the embryo to form the permanent amnion. Yet this might be properly considered as in the beginning the least important part of it.

The amnion starts out at first from the margins of the external ventral plates, that is, from the epiblast and the outer half of the mesoblast, as if for the purpose of inclosing the umbilical vesicle in still an additional layer of membrane. This membrane, starting out from the abdominal surface of the embryo, grows outside of the umbilical vesicle until it forms a complete sac over it and on the inner surface of the chorion. The sac so formed is then folded or tucked up over the body of the embryo until the folds meet above, where a union takes place between them. The inner layer of this fold is now separated from the outer one, which thus forms a complete sac within the chorion, disappearing almost as soon as found. The inner fold forms the true amnion.

We do not pretend to say that the early stages of embryonic development have not been fully understood by the able investigators who have made the subject a special study, but we think it can be claimed with reason that no work has made the various steps of the process sufficiently easy to understand.

### Notes and Queries.

**A MEDICAL DEFENSE UNION.**—In these days of actions for malpractice and threats of suits, the minds of medical men are often turned toward the possible means of protection. Nothing has yet been suggested that seems to meet the emergency, but in England there are means taken which may not be wholly inapplicable to our own country. English journals have recently reported the meeting of a Medical Defense Union, of which Mr. Lawson Tait is the president, and Dr. Granville Bantock the treasurer. The objects of this asso-

ciation must commend themselves to our medical men, as it attempts to protect individual members against vexatious proceedings and attempts at blackmail, and also to check irregular practice.

The annual report shows that the forces of the Union have not yet been called into play to defend an action at law brought against a member on professional grounds, but that the organization and funds of the Union will allow this to be done at any time. It is pointed out that the first important case of this description, which may occur at any time to any one, will at once and for all justify the existence of the Union in the eyes of even the most obtuse and improvident member of the profession, and we shall not be outraged by seeing in the columns of the medical journals the oft-repeated appeal to charity for funds to defend a medical man in trouble. Important cases of this class occur comparatively seldom, and the chief work of the Union has been in minor though important channels; but it may confidently be asserted that the existence of the Union alone has been the means of preventing more than one action being brought against medical men. The energy of the Union has also been directed to check irregular practice, but with only partial and unsatisfactory results. The chief and most notorious advertising quacks appear to have studied the law very carefully, and know how far they may safely go. One piece of work mentioned as accomplished by the Union is, materially helping in securing the conviction of an alleged spiritualist and faith healer, with an American diploma, for assaulting a young girl under his care.

It is to be hoped that the experience gained by this English Union may at some time prove of service in the formation of an American society with a similar object.—*Boston Medical and Surgical Journal*.

**CHOLERA: A SUGGESTED REMEDY.**—A short time ago M. Loewenthal had a note read for him at the Academy of Sciences in which he gave the result of his researches on the microbe of cholera and its inoculation. He then conducted certain experiments on animals with the salicylate of phenol or salol,

and had reason to conclude that he had found in this substance a remedy for cholera. Professor Cornil read a report of these experiments at the Academy of Medicine, on Tuesday last, in which he stated that, to obtain conclusive results, one must be able to inoculate animals with cholera in a manner as simple and as certain as that which we possess for the transmission of charbon, for example, or of tuberculosis. In the absence of this condition the effects produced can not have the necessary demonstrative significance. Notwithstanding this, added M. Cornil, the results of the experiments of M. Loewenthal are always of a nature to furnish one more indication for the trial of salol against cholera in man.—*London Lancet*.

**THE FORMATION OF HEMOGLOBIN IN THE SPLEEN.**—Dr. Krieuger, of Dorpat, has made a number of experiments on cats, with the aid of Hüfner's spectro-photometer, for the purpose of discovering whether the amount of hemoglobin contained in the splenic artery is greater than that in the splenic vein. He found that the quantity of blood in the splenic vein amounted to 9.52 per cent, while in the artery it was only 9.28 per cent. From these researches he came to the conclusion that hemoglobin is actually formed in the spleen. The results are quite consistent with those obtained by different methods by Drs. Malassez and Picard in France, and by Drs. Pashiutin and Vinogradoff in Russia. It is of course well known that there is a considerable quantity of iron in the tissue of the spleen, consequently there is no inherent improbability in Dr. Krieuger's theory.—*Ibid*.

**INGLUVIN IN THE VOMITING OF PREGNANCY.**—Dr. Popp (*Pester Med. Presse*, No. 40, 1888) reports having achieved considerable success with ingluvin in the vomiting of pregnancy. Having a very obstinate case, upon which he had exhausted the entire resources of the pharmacopeia, he administered three times daily, one half hour before meal-time, eight grains of ingluvin, and directly afterward two tablespoonfuls

of one-per-cent hydrochloric-acid solution. An improvement was observed after a few doses had been taken, and a cure effected after the treatment had been continued for three weeks.—*Deutsche Med. Wochenschrift*, January 17, 1889.

**HALL OF THE COLLEGE OF PHYSICIANS.**—The first triennial prize of two hundred and fifty dollars, under the deed of trust of Mrs. William F. Jenks, has been awarded by the Prize Committee of the College of Physicians, of Philadelphia, to John Strahan, M. D., M. Ch., M. A., O. (Royal University, Ireland), 247 North Queen Street, Belfast, Ireland, for the best essay on "The Diagnosis and Treatment of Extra-uterine Pregnancy."

The writers of the unsuccessful essays can have them returned to any address they may name, by sending it and the motto which distinguished the essay to the chairman of the Prize Committee, Ellwood Wilson, M. D., College of Physicians, Philadelphia.

The trustees have made arrangements with Messrs. P. Blakiston, Son & Co., 1012 Walnut Street, Philadelphia, for the publication of the successful essay, which will also appear in the Transactions of the College for 1890.

JAMES H. HUTCHINSON,  
JOHN ASHHURST, JR.,  
JAMES V. INGHAM,  
*Trustees of the William F. Jenks Prize Fund*  
PHILADELPHIA, Feb. 19, 1889.

**ACTINOMYCOSIS HOMINIS.**—At the last meeting of the Royal Medical and Chirurgical Society a very remarkable and complete demonstration was furnished by Professor Crookshank of specimens of bovine and human actinomycosis, as bearing on the case brought forward by Dr. Douglas Powell. The disease, at any rate among animals is probably far more common than is generally supposed, its natural history not having as yet been fully elucidated. Recent researches have, however, gone far to improve our knowledge of the subject. This demonstration pointed strongly to the identity of the disease in man and animals, i

spite of certain striking differences which are explained by assuming the polymorphism of the parasite. Professor Crookshank has succeeded in making some very successful cultivations, the identity of the organism having been demonstrated by inoculation experiments. It appears as if we were only on the threshold of a series of discoveries in reference to the pathogenetic powers of this new-comer, and the achievement will reflect the greatest credit on microscopy as a source of exact and reliable information.—*London Medical Press.*

**STRANGE CURES.**—For hydrophobia, the most deadly and most feared of all the accidents and ills to which man may be liable, there is a locality in England where the following treatment is believed in: The afflicted person must be laid on his back; then his nose must be pricked three times and three passes of the hand made over him, while these words are recited with solemnity and due emphasis, "I am thy Savior, lose not thy life!" After that he must be enveloped in blankets to "sweat him," and pills must also be administered to him made of the skull-bone of a man who has been murdered or who has met with a violent death; the result being that the sufferer unfaillingly recovers!

In some of the southern shires it is considered that three sips of sacramental wine are an unfailling cure for attacks of intermittent hiccough.

Should smallpox make its appearance in a house, a frog must be dried alive in an oven, and then stitched up in a bag and hung round the neck of the person attacked by the fell disease, whereupon this also will disappear with magical rapidity. — *Florence Layard, in the Chemist and Druggist; Edinburgh Med. Journal.*

**THE COPYRIGHT OF NAMES OF DRUGS.**—Homatropin, a derivative of atropin, was brought into notice a few years since by Mr. John Tweedy, who published a paper on the physiological action of the drug. Soon afterward its value in the treatment of the night sweats of phthisis was precognized by Dr. Murrell in the Practitioner. It seems

that Merck, of Darmstadt, has copyrighted the term homatropin, and has entered it under the Trade-mark Act in the United States so as to bring it within the category of patent medicines. It is to be hoped that this step will not be allowed to pass unchallenged, as otherwise the practice may degenerate into a nuisance, and some enterprising chemist may lay claim to apomorphine and other terms of modern introduction. There is perhaps no great objection to a right of property in such fancy terms as antipyrin or antifebrin, but, when scientific terms are menaced with a similar fate, chemists and others will do well to protest. *London Medical Press.*

**POST-MORTEM WARTS.**—The *post-mortem* warts, says Dr. Wm. Osler, are now pretty generally regarded as local tubercle, the result of inoculation. The presence of bacilli has been demonstrated in several instances. The tubercles consist chiefly of granulation tissue, occasionally with giant cells and with papillomatous outgrowths of the epidermis, which give the tubercle the wart-like character. They are met with in persons who perform many *post-mortems*, and in those whose business brings them into close contact with animals and animal products. Their occurrence is by no means infrequent. In Germany it is quite common to see the hands of the demonstrators of pathology (and more especially the attendants in the autopsy rooms) disfigured by these structures. Mr. Hutchinson considers these warts a form of lupus.—*Medical Record.*

**THE LAMB PRIZE ESSAY.**—The Secretary of the American Public Health Association announces that the essay entitled "Practical Sanitary and Economic Cooking for Persons of Small Means," to the author of which was recently awarded the Lamb prize of \$508 dollars in gold, will soon be issued from the press.

The essay is declared by the committee to be of unusual merit, and the secretary asks that it be not prejudged unfavorably by those who have seen the recent mutilated print of it in the New York Herald.

**MYRTOL AS A DISINFECTANT OF THE RESPIRATORY PASSAGES.**—Dr. Eichhorst (*Ther. Monatshefte*, January, 1889) recommends myrtol as a disinfectant of the respiratory passages. Myrtol is a clear fluid, has a refreshing odor, and is that portion of the myrtol oil which melts at 158° to 170° F. It is best administered in capsules containing two and a half grains each, of which from two to three are taken daily. One hour after its administration its odor is perceptible in the patient's breath. The curative effect is said to be rapid, especially in putrid bronchitis and pulmonary gangrene. Myrtol exerts no action over the tubercle bacillus. The intestines of patients who have died while taking this remedy retain the odor of myrtol for some time.—*Maryland Medical Journal*.

**GLYCERINE IN EMULSIONS.**—A recent number of the *National Druggist* tells us that Mr. Burnett has found an improved method of keeping bismuth salts from depositing. He says that if a little glycerine be added to mixtures in which the salts of bismuth are held in suspension in mucilage of gum arabic or gum tragacanth, the metallic compound will not separate so readily. Moreover, the mixture will be made more homogeneous, and in a shorter time, by shaking, than it will if made without the glycerine.

**THE American Association of Genito-Urinary Surgeons** says that it will not consider the application for membership from one who on his card states that he is a genito-urinary surgeon. He can do this in connection with his papers in medical journals, and with the reprints of the same, in the announcements of the dispensaries, etc., with which he is connected. By these means he may advertise his specialty among the people and the profession, but he must not do the same thing with his cards.—*Maryland Medical Journal*.

**ESCHSCHOLTZIA CALIFORNICA: A NEW HYPNOTIC.**—Ter-Zakariantz speaks highly, in the *Semaine Médicale*, No. 52, of a new hypnotic—*Eschscholtzia californica*. It belongs to the family of the papaveraceæ, and he

declares it to be both a valuable hypnotic and a very useful anodyne, and, being harmless, preferable to morphine. It can be administered in the form of a potion, of a syrup, or in pills in daily doses of thirty-seven and a half to one hundred and fifty grains. Several formulæ are given by him. *Weiner Med. Presse*.

**FOR WHAT ARE DOCTORS PAID?**—An English judge has recently given a decision containing a great deal of common sense. A local surgeon sued the executor of a deceased farmer for an amount for consultations. The deceased could not take any medicine. The judge, in giving his decision, said: "Many people of a better class hold the idea that it is medicine doctors are paid for. It is for skill."—*Lancet and Clinic*.

**THE deaths in Philadelphia, for the week ending February 23d, numbered 347. There were 11 deaths from scarlet fever, 18 from typhoid fever, and 7 from diphtheria.**

**THE fund for promoting the study of the treatment of tuberculosis, which is being raised in France, amounts now nearly to \$15,000.**

**THE homeopaths of New Haven are trying to get money to build a hospital. It is asserted that half the property in New Haven is owned by homeopaths.**

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### SPECIAL NOTICE.

THE CINCINNATI MEDICAL JOURNAL is issued on the 15th of every month. Each number contains 76 pages including cover, on best sized supercalendered book paper, with glazed plate cover. Edited by A. B. Thrasher, A. M., M. D.

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# THE AMERICAN PRACTITIONER AND NEWS

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*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.*

## Original Articles.

### THE MANAGEMENT OF TYPHOID FEVER.

BY H. M. GOODMAN, M. D.

*Assistant to the Chairs of Physiology and Pathology and Chemistry and Microscopy, University of Louisville*

Of all questions with which we are concerned, there are none involved in more uncertainty or that have produced more varying opinions than the management of typhoid fever. Embarrassing as this subject is at first glance, it becomes more so when we consider that an interval of from six to eight days must frequently elapse from the establishment of fever before a positive opinion can be given as to the nature of the affection. The disease in the outset is often treated under the supposition that it may be of malarial origin, and after a week or more of the most heroic treatment the patient is informed that his trouble is typhoid fever, and that a certain time must elapse before he can hope to be well. With an insidious foe to contend with, and a constitution already weakened from the disease as well as by hyper-medication, the case too often proves fatal when such a result is entirely preventable. Given a case of acute fever in which there is no discoverable sign of disease, but simply fever with its attendant phenomena, are we justified in invoking the aid of every known antipyretic with a view of dissipating the fever, or is it not better to wait until the disease becomes so pronounced as to remove all uncertainty as to its nature before adopting extreme measures to effect a cure? From an emotional standpoint we

would doubtless be exonerated from all blame in the event of a fatal issue; but, viewed in the light of reason, there can be no excuse for any of us who rush blindly ahead administering medicines to reduce high temperature when we are in doubt as to its origin. One thing is very certain, and that is, if we do not succeed in accomplishing our object (that is, the reduction of temperature), we will too often produce disturbances of the heart and digestive organs, which are frequently more troublesome to treat than the disease itself. When once the diagnosis is established, the course we are to pursue becomes plain. Having no specific for this disease, all efforts toward specific treatment must prove futile. The remarks I have already made in regard to the antipyretic treatment, in the beginning of all doubtful fevers, apply with equal force during the course of typhoid fever. All fevers are more or less conservative, and are necessary concomitants to many morbid conditions of the body. Let us consider for a moment traumatic fever: You get a slight scratch upon the hand; the parts in immediate proximity become swollen; there is redness for an eighth of an inch upon each side, within which area the temperature is elevated. The irritation thus produced exercises an influence, not on the general nervous system but on the inter-muscular ganglia, and the changes go on more or less rapidly in that part and produce fever in that part. If the wound is sufficiently extensive, then the ganglia of the nervous system at large are affected, and as a result you have an inhibitory action affecting the whole organism, and the changes from altered nutrition in these parts go on and cause tissue metamorphosis with an elevation of the temperature. No one will pretend to say that the minor lesion will heal without the local inflam-

mation; and why is not the general disturbance of the system and fever as necessary for the reparation of the greater injury? In all zymotic fevers there are local lesions (in the exanthemata these affect the skin chiefly) resulting from the presence of a morbid germ. In certain portions of Asia, where the drinking-water is very filthy, the ova of a species of worm are taken into the stomach, pass into the blood, and finally lodge in the tissue beneath the epidermis, where they mature, and, ultimately protruding, are expelled. During the maturation of the insect there is local inflammation and suppuration and general febrile disturbance. So in typhoid fever, where we have a local inflammation of Peyer's patches, fever is as necessary to its cure as the local inflammation is to the healing of a wound; differing from a simple traumatism, however, in that in addition to the local lesion there is developed in the blood a specific organism which becomes an important factor in the production of fever.

Almost every practical observer is familiar with the growth of the *saccharomyces cerevisiæ*. When a small drop of yeast is placed in a fermentable liquid containing some form of nitrogenous matter in addition to the sugar, the yeast cells undergo multiplication, and by their growth induce changes in the surrounding fluid which result in the breaking up of the molecule of sugar into alcohol and carbon dioxide with the production of heat. Reasoning from analogy, is it not plausible to suppose that the growth of the typhoid-fever bacillus in the blood produces disorganization of the blood by a species of fermentation with an elevation of temperature? Here, then, we have two causes for the fever, one the growth of a bacillus in the blood, the other a traumatism resulting from the action of the specific poison upon certain tissues. The growth of the bacillus in the blood preceding the local lesion, and the height of the fever indicating the degree of the systemic poisoning under the action of micro-organisms, this growth continuing until the pabulum becomes exhausted, and the traumatism passing through the successive stages of inflammation from simple congestion to ulceration, necessarily require a certain time

for their completion. If the strength of the patient can be maintained until these changes occur, convalescence becomes established. Consequently, it is apparent that all forms of antipyretic treatment (exerting, as they do, no specific action over the disease) really do harm by interrupting the growth of the bacillus, interfering with the healing of the bowel and lowering the vitality of the patient. Until some germicide is discovered that can remain in the blood in sufficient quantity to destroy the bacillus and prevent the traumatism of the bowel without injuring the patient, our duties in the management of all cases of typhoid fever may be stated briefly as follows

1. The room should be as large and as well ventilated as possible, and the temperature should be maintained at about 70° F.

2. Absolute rest in bed in the recumbent position should be insisted upon so long as fever exists.

3. No kind of food which produces a large amount of excrement to pass over the inflamed bowel should be allowed.

4. The prevention of all exhausting discharges and the maintenance of the strength of the patient until the period of convalescence becomes established.

5. Avoid the administration of antipyretics as they interfere with the normal evolution of the disease, and instead of hastening its termination really prolong its duration and debilitate the patient.

6. The thorough disinfection of all discharges by some agent capable of destroying the germ.

7. As much care should be observed in the management of the case while convalescent as in the height of the fever.

The proper temperature of the room and the admission of an abundance of fresh air, with the avoidance of all draft over the patient in the treatment of this disease are necessities whose virtues call for no discussion. With a traumatism located in the small intestine, and the knowledge that perforation of the bowel and general peritonitis are only too often the termination of the so-called "walking case of typhoid," the importance of rest can not be too strongly impressed upon the patient. The value of rest in the treatment of all inflammations

ions has been so clearly elucidated by Hilton in his classical work on "Rest and Pain," that the necessity of it in the management of this disease is obvious when we consider the traumatism in the bowel. Physiological rest is secured by absolute maintenance of the recumbent position and the avoidance of all stimulating foods, while therapeutic rest (in all cases where there is great pain or a tendency toward diarrhea) is gained by the cautious use of opium or some of its preparations. The proper food and the remedies to be used in checking the various discharges, whether they take the form of excessive vomiting, diarrhea, or hemorrhage from the bowel, will be found fully enumerated in the various text books that I shall not enter into their consideration.

I will mention, however, in passing, that frequently constipation exists (particularly in cases where milk is the exclusive article of diet), and that I make it a rule never to allow the patient to go more than four days without an action from the bowels. In order to move the bowels, a seidlitz powder every two hours until three or four are taken, or if this fail, an oil-and-water injection will generally produce the desired result. The strength of the patient is to be maintained by diet and the proper use of stimulants. The incautious use of stimulants is frequently the means of producing the very effect they are given to avert. They produce a condition of artificial exhilaration for a time, and as the effects wear off the depression is apt to be correspondingly great. I do not think their use is indicated except in cases of threatened heart failure or in a very rapid and weak pulse with great depression of the vital powers, and even then they should be cautiously administered and their effects carefully observed. I have found quinine in small doses a remedy that exerts the most happy tonic effect over the action of the heart, and generally give it during the entire course of the disease. The administration of the dilute mineral acids exercises a calmar action over the entire system, and for this reason it is generally advisable to give them.

The relief of symptoms and the treatment of complications are to be regulated by the de-

mands of individual cases. Clinical experience indicates that the danger of infection arises only from contact with the intestinal contents; the contagium not being contained in the exhalations of the patient, it is not conveyed to those who may come in contact with him. The virus may enter the intestinal tract through the mouth along with the food or drinking-water, or it is diffused from the feces into the air, enters the pharynx, and then is swallowed. In view of these conditions, the greatest care should be exercised to thoroughly disinfect the feces, bed-pans, and all soiled articles of clothing. For this purpose there is no agent so destructive to all forms of germ life as the application of heat. Wherever practicable it is advisable to subject every thing that has been contaminated by the feces to thorough sterilization by either dry heat or by boiling them for several hours. When such a course can not be systematically carried out, it is best to expose these articles to the action of such germicides as corrosive sublimate, sulphurous acid, or sulphate of iron. It is a wise precaution to see that a certain amount of a solution of one of the above substances is daily thrown into all water-closets and vaults about the premises, and under no consideration should the feces be thrown into the vault without thorough disinfection.

When convalescence begins, the duties of the physician have not yet ended. The patient should be told that a relapse may follow any slight imprudence, and that it is absolutely necessary that he should maintain the recumbent position for at least a week after the subsidence of all febrile symptoms. He may then be allowed to sit up in bed a little each day, say one hour in the morning and one hour in the evening of the first day, increasing an hour morning and evening each succeeding day until he is able to sit up in bed for the period of one whole day, when he may be allowed to sit up about the room. During all this time the diet of the patient is to be the same as before, the return to solid food being made slowly, beginning with the least irritating and gradually resuming the normal diet. With such a course I am satisfied, from personal observation, that nature is given time to heal the

traumatism of the bowel, and that the tendency toward relapses is reduced to a minimum, while the chances for recovery are very much enhanced.

LOUISVILLE.

### SUPPLEMENTARY REPORT OF FOUR CASES OF ATYPICAL TYPHOID OR TYPHO-MALARIAL FEVER.\*

BY T. B. GREENLEY, M. D.

At the December meeting of the Hardin County Medical Society, I read a report of eleven cases of this character of fever, which was published in the *American Practitioner and News* of January 5, 1889. Since then I have treated four more cases, which I now report.

Called to see B. O., December 11, 1888, aged twenty-five, stout, and naturally of good health; has been employed on a floating saw-mill for several months; had been sick in bed a week before I saw him, and under the care of a physician at Mauckport, Indiana. Was taken with a chill and reactive fever; complained of headache, anorexia, with torpid kidneys. Bowels inclined to be loose; restless, and could not sleep. Temperature, 102°; pulse, 84. I had him moved on shore, and prescribed quinine, Dover's powder, and salicylate of ammonia, of each five grains, at intervals of four hours. This treatment had the effect to render him quiet and to procure sleep; it also produced some diaphoresis. Nitric ether was given as a diuretic.

13th: Temperature, morning, 101°, evening, 102.5°; pulse, 84; kidneys acting better; skin moist, and patient comfortable. Diet, fluid, consisting mainly of milk. Continued treatment at intervals of six hours.

The disease continued about the same until the 18th, when morning temperature fell to 100°, the evening temperature reaching 102°; pulse, 80. Continued treatment, substituting nitrate of ammonia for the salicylate.

22d: Temperature, morning, normal, evening, 100°; pulse, 76. Continued treatment.

25th: Temperature normal morning and

evening; pulse, 72. Continued treatment a day longer. The fever in this case lasted three weeks from time of onset.

CASE 2. December 12th, called to see Maude B., aged nine years; rather delicate child, subject to asthmatic attacks since in fancy, but for about two years has escaped, was taken two days ago with a chilly feeling and fever, with headache. Temperature, morning, 101°, evening, 103°; pulse, 104. Prescribed quinia, Dover's powder, and salicylate ammonia, of each two grains, every four hours. Fluid diet, milk, soup, etc. Continued treatment two days.

14th: Temperature same morning and evening as on the 12th; other conditions about same. Continued treatment at intervals of six hours.

18th: Condition same. Treatment continued, substituting nitrate ammonia for the salicylate.

23d: Temperature, morning, normal, evening, 101°; pulse, 84. Treatment continued.

25th: Temperature normal morning and evening. Continued treatment one day longer. Dismissed.

CASE 3. December 13th, saw C. B., aged twenty-three, and brother of Case 2. Has been complaining of being unwell for several days, with slight headache, etc. Temperature, 102°; pulse, 112. Quinia, Dover's powder, and nitrate ammonia, of each five grains, every four hours.

15th: Temperature, morning, 101.5°, evening, 102.5°; pulse, 112. Treatment continued at intervals of six hours. Fluid diet of milk and soup.

23d: Temperature, morning, normal, evening, 101°; pulse, 84. Treatment continued.

25th: Temperature, morning, 100°, and evening, 102°; pulse, 96. Treatment continued, with three grains acetanilide. Owing to his appetite being better yesterday, at the request of his mother, I allowed him to have some beef to chew, with the understanding he was to spit out the pulp and swallow only the juice. His mother thinks he swallowed the beef, as she saw nothing of it afterward.

From this time he was more or less delirious.

\* Read at the meeting of the Hardin County Medical Society, March, 1889.

ious, with incoherent mutterings, and pulling at the bed-clothes.

28th: Temperature, morning, 101.5°, evening, 103°; pulse, 108. Still delirious, with some diarrhea. Continued treatment.

January 2d: Temperature, morning, 102.5. Died in afternoon.

This patient was greatly prostrated with a previous attack. His was Case 11 in the first series of my report. He had been up only about a week when he was taken with second attack. Up to the end of the second week I was hopeful of his recovery, as the disease seemed to be of a mild character; but after the sudden change on the 25th, due to eating beef, as his mother surmised, the case soon became apparently hopeless.

This was the sixth case occurring at the same house, but as to the cause I could not satisfactorily determine. The house was well up off the ground, and comparatively new. The cistern-water was not good, and on examination showed a considerable amount of organic matter. When Cases 2 and 3 of this series occurred, I directed the family to suspend the use of the water.

On inquiry, I learned from the mother of the patients that she had not drank any of the water all summer and fall on account of its peculiar smell and taste.

When she wanted a drink she would simply wash her mouth with it. She claimed that it smelt and tasted like rotten wood. Whether or not the cause of the disease was due to contaminated water it is hypothetical to say, but it is very evident there existed a local cause, and the inference is that it existed in the water. The mother was the only member of the family who escaped the disease.

CASE 4. January 27, 1889, was called to see Blanche L., a child of five years. Temperature, evening, 102.5°; pulse, 116. Has not been well for a couple of days, complaining of headache and some fever. No appetite; bowels costive.

*Treatment:* Quinia, Dover's powder, and strate ammonia, of each one and a half grains, every four hours. Hyposulphite soda

as a laxative. This treatment was continued three days without any change as to temperature.

January 30th: Temperature, morning, 101.5°, evening, 102.5°; pulse, 112. Continued treatment at intervals of four hours. Diet consisted of milk, soup, etc.

February 8th: Temperature, morning, normal, evening, 100°; better appetite; allowed her a soft boiled egg in addition to the milk, etc. Continued treatment.

February 11th: Temperature was normal morning and evening. Treatment continued one day longer. Dismissed.

*Remarks:* Out of fifteen cases of this peculiar fever I lost three patients, one from heart failure, due to imprudence in getting up and going out of doors, and two from indiscretion in eating—one a sour orange, and one a piece of beef, as supposed. These three cases were, up to the end of the second week, as mild in character as any of the series.

The backsets and fatal results in these cases illustrate very clearly and truthfully the statement of Dr. Dabney, of Virginia, that the mildest cases may, by imprudence in diet or physical exertion, be converted into those of a dangerous and fatal character. The whole number of the two series of cases occurred in families who were poor and to some extent unable to have the necessary nursing, diet, etc., and at houses where the sanitary surroundings were not of the best. I believe, if I could have had at command every thing necessary in the way of nursing, etc., together with proper sanitary surroundings, that each of the three fatal cases would have recovered. The fourth case of the present series occurred at the house where the second and third were sick, but some time after it had been cleaned up and thoroughly ventilated, and the cistern emptied and cleaned out, the other family having vacated and a new family moved in. I think the child took sick in about two weeks from the time it moved in.

In this case we can not charge the cause of the disease to the water. The last case made six I had treated in that house.

In studying the history and characteristics of this fever, I arrived at the following conclusions:

1. It is different from any form of fever I have heretofore seen, either of the typhoid or so-called typho-malarial fever, except the third case of the present series, which in some respects resembled the latter disease in the last week.

2. The only two symptoms, in a large majority of the cases, which resembled those of typho-malarial fever were the exacerbations of evening temperature and the slowness of the pulse in proportion thereto.

3. That none of the cases could be traced to the influence of contagion, there having been no cases in the neighborhood for years.

4. The cause, in our best judgment, was hypothetical.

5. That those cases which died were as mild in character during the first two weeks as any of the series, which induces me to believe that under proper nursing and sanitary surroundings they would have gotten well.

6. That proper nosological position of the disease is yet to be determined.

WEST POINT, KY.

### A CASE OF VARIOLOID.\*

BY T. B. GREENLEY, M. D.

On the 25th day of January, 1889, was called to see Mr. S., aged fifty years, in Harrison County, Indiana. His temperature was 101°; pulse, 106. Complained of pain in head and back, with a sensation of constriction across the lower part of chest. Had quite a thick eruption, covering face, body, and extremities down to wrists and ankles; on feet and hands but scattering. Scalp also broken out.

Two days before I saw him he had a chill and reactive fever, with all the subjective symptoms above detailed.

I could but regard his case as one of varioloid, as the eruption was now well developed—some in the forming-stage, and some

in the vesicular form. The mystery was, how did he get it? On inquiring, I learned he had been in Louisville, and had visited the auction houses just ten days before the onset of the disease. I had him isolated from the remainder of the family in a room upstairs, and no one to attend on him or communicate with him but his wife, who, on examination, I found to be well protected by a perfect vaccine scar. Mr. S. had been vaccinated, but had an imperfect mark.

I found that several of his children had not been vaccinated, and the two who had been showed imperfect scars. As the patient's bowels were torpid, I directed magnesia sulphas in laxative doses. After giving general orders for non-communication with any of the neighbors, and ordering them all on milk and mush diet, I promised to return in two days and vaccinate the family, having to go to Louisville for the vaccine.

January 27th: Saw Mr. S. again to-day; temperature normal, and the distressing symptoms of back, head, and chest disappeared. Feels comfortable, except for the unpleasant effects of the eruption. To-day could see the three stages of development, to wit, the red point, the vesicle, and the pustule—some of the oldest of the latter beginning to umbilicate. Only a very few of the first to be seen. I now vaccinated the whole family except the wife (who, as before remarked, had a perfect scar), including the house-girl. Continued isolation of Mr. S., with wife as nurse, etc.; also, left several points (bovine) of vaccine with Mrs. S., telling her that in case no signs of vaccinia were manifested in the children's arms in forty-eight hours, to re-vaccinate them.

February 7th: Saw the family again to-day. Mr. S. is well, the crusts having all dropped off and left no pits. Owing to the slowness of the bovine matter taking effect the influence of the varioloid seemed to be exerted on the systems of the children to a slight extent, except the baby, who entirely escaped any eruption.

The oldest boy had but very few pimples—none pustulating—and said he felt entirely well. None of the family affected—five in

\*Read at the meeting of the Hardin County Medical Society, March, 1889.

number—was sick enough to go to bed. The wife had no symptoms of the disease. The vaccine took on all, but very tardily. I did not again visit the family, but directed them at the expiration of ten days more to have a general cleaning up, disinfecting the house and its contents, giving particular directions how to proceed.

Owing to the strict non-intercourse with the neighbors not a single case occurred outside of the family affected.

*Remarks:* At first I was somewhat puzzled as to the diagnosis, as varicella in several characteristics is very similar to those presented in varioloid. I arrived at the diagnosis in this way. In the first place chickenpox is not very common in old people, although it occasionally happens, and neither is it so contagious as smallpox. In the second place the patient had a more general eruption than I had ever seen in chickenpox, and suffered more severely from constitutional symptoms. Then, again, the presence at the same time of the three different stages of the eruption was characteristic of varioloid.

In the winding up of the trouble I am still more fully convinced of the correctness of the diagnosis, from the fact that the baby and its mother had no eruption, and further, that in one or two of the children the eruption was virtually aborted in the primary stage of development.

WEST POINT, KY.

### BORIC ACID AND OIL OF CACIA AS WOUND DRESSINGS.

BY DAVID PRINCE, M. D.

Some years ago a coal miner got so burned by gunpowder that his eyes were destroyed, and small patches of skin over large surfaces soon exfoliated. The patient was being placed in a bath at full length every day, and the wounds dressed with poultices, but the sloughs came to smell, and the constitutional symptoms were those of blood poisoning.

As soon as powdered boric acid was put over the sloughs the symptoms amended rapidly and the patient recovered. Still it

did not occur to me to employ boric acid in large quantity in all kinds of wounds and for the purpose of preventing putrefaction as well as for counteracting it. I have but recently begun to cover with boric acid either stumps or such flaps as must almost necessarily slough, but which are not cut off at the time of operation, on account of the danger of bleeding or in order to save all the material possible.

A good example of this is afforded by the removal of the upper portion of the uterus for fibroid growth, or in Porro's operation. It is ordinarily desirable to cut away as much substance as possible; and yet to shave too close to the ligatures invites hemorrhage and the disasters of a slipping wire or other form of clamp. When putrefaction in the stump and septic absorption can be got rid of, it will become the practice to leave a large amount of material outside the ligature or the clamp.

The first time I acted on this principle was in an operation for the removal of a large fibroid from the pelvis.

The fundus of the uterus extended above the umbilicus, but the widest part of the tumor was transversely on the level of the promontory of the sacrum. I could not raise enough of the tumor to get the chain around a pediculated portion of it. So large a mass was embraced by the chain that there was a great amount of tissue left ready to putrefy. After the stitches had been taken and coaptation made between the side of the tumor beneath the chain and the peritoneal surfaces, the stump was covered deep in powdered boric acid, this covered with cotton and retained by a roller bandage.

The first dressing was made on the thirteenth day, when the dead mass exhibited no odor. The boric acid was applied as before, but at the next dressing there was some odor. The boric acid was again used and intermixed with oil of cinnamon (oil of cacia), after which there was no more odor.

To deodorize dead tissue in a stump attached to the body may be considered a great advance in surgery. It was found, however, in the above case, that where the

oil of cinnamon touched the skin it made a blister. Taking a lesson from this, greater care was afterward taken to bury the oil in the boric acid, so that it would not come in direct contact with the skin, when it was found not to irritate.

*Boric Acid Applied to an Open Wound.* Patient seventy years old. Osteo-sarcoma of the middle portion of the humerus, resulting in complete destruction of the osseous tissue, accompanied by great pain. Amputation done without flaps, depending upon the gliding nature of the skin of the trunk to permit an ultimate covering of the wound. The axillary artery was tied before being divided. Very few subordinate vessels required ligation. After cessation of oozing, the raw surfaces were covered with small pieces of muslin saturated with carbolic acid; over these dry boric acid in considerable quantity, and ordinary cotton, all being retained by a bandage.

Very soon after recovering from the anesthetic patient expressed relief from the pain, and in six days he was walking around town. No reverse occurred during his recovery. The dressing was changed only when fluid appeared under it, and no water was applied at any time after the first dressing.

In deep wounds purposely or unavoidably left open, as in those made for the removal of a sequestrum from a cylinder of bone, the plan suggested is to fill the opening with carbolic acid, cover this with boric acid held in place by cotton and roller bandage. The carbolic acid forms, with the blood and other albuminoid fluids, a slightly soluble crust, which is afterward slowly dissolved. Carbolic acid, with only water enough to make it liquid, is always safe upon exposed surfaces. The slow solubility of the crust accounts for this.

The ideal of a surgical dressing implies:

1. An agent which is not irritating.
2. One which will absorb any fluids that may escape and form a compound with them capable of resisting the ferments of the air.
3. One which will allow no neutral under surface where putrefactive changes may

creep along the skin under the dressing and carry infection from without to a wound not completely closed.

These points can be affirmed of no substance which becomes solid or is completely insoluble. They can not be affirmed of any gauze, or absorbent cotton, or wool, for all of these are capable of forming compact layers next the skin, out of which any antiseptic with which they may have been infiltrated may have been lost or neutralized, permitting germ-bearing air to insinuate itself under the dressing. A sparingly soluble powder, applied in such quantity as to be more than enough to absorb the exudates which escape from wounds, meets the desideratum. Many agents have been on trial, and, so far, that which has given the greatest satisfaction is powdered boric acid. The under crust, combined with blood or pus, is antiseptic and only sparingly soluble. These conditions prevent in greatest degree the exudates from decomposition.

The smarting effect of boric acid, when applied to a clean granulating surface, disappears after its combination with the exudates from the parts. If, however, the surface is free from sinuses or hiding places, there is no advantage in washing off the covering of the granulations, and the only excuse for redressing is the curiosity to inspect the wound.

Narrow strips of aseptic gauze or lint, spread with any aseptic oleaginous covering, may protect these delicate surfaces. These applications having openings, there is ready absorption of exudates which appear in much quantity. The oil of cacao, supplies to the antiseptic element of the dressing the quality of diffusibility.

Dr. G. V. Black, Professor of Pathology in the Chicago Dental College, has worked out the antiseptic qualities of oil of cacao, and has found that cinnamon-water arrests putrefaction in a culture medium when added to it as one to four. The diffusibility by which it readily combines with all parts of the culture liquid gives it a great practical advantage over many other antiseptics of greater power when thoroughly com-

bined. The advantage of this quality for a wound dressing will be readily appreciated.

In amputation of the breast on account of malignant growth, in cases in which the wound, from choice or necessity, has to be left open, the best method is a covering with carbolic acid on small slips of gauze, over which is placed dry boric acid in considerable thickness, this being covered by cotton and a bandage. The exudates find ready means of escape, making crusts with the boric acid which do not undergo decomposition.

The oil of eacia has also another quality, that of preserving solids, acting like creosote in preserving meat against putrefactive invasions. When septic changes are already present in deep wounds, like the sinuses about large joints, boric acid is not the most efficient agent for destroying infection. Sublimate solution  $\frac{1}{1000}$  to  $\frac{1}{10000}$ , cinnamon-water, and peroxyde of hydrogen hold the first rank in such conditions. They make the best means for destroying putrefaction in its hiding places. While sublimate may be the most active antiseptic as to immediate action, its ready decomposition and its want of diffusibility impair its reliability.

JACKSONVILLE, ILL.

## Correspondence.

### PARIS LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Prof. Fournier, the well-known syphilographer, lately delivered a lecture at the Hospital St. Louis on the treatment of syphilis, by subcutaneous injections with solutions of mercury. The lecturer observed that this method of treatment, though still comparatively in its infancy, has already been divided into two different procedures. For the first, which is the most ancient, a soluble mercurial compound is injected. Small doses are employed, and the injections are frequently repeated. In the second, which is the more recent, massive injections at long intervals with an insoluble mercurial compound are used. But of all the proced-

ures, after prolonged experience, solutions of corrosive sublimate have been found the most suitable. After a comparative review of the various methods employed for the cure of syphilis, Dr. Fournier concludes that, while admitting that the hypodermic injections have a curative action, nothing establishes their superiority over the other modes of treatment, because, (1) till now with these injections one attacks syphilis only at its commencement, when the accidents are spontaneously resolvable; (2) the method has not the same success when one has to deal with grave accident; (3) to determine the curative action of injections, it requires further experience. The following are the advantages allowed: The injections have a powerful and rapid action on the secondary accidents; they are generally well tolerated by the organism and the intestines; they exclude all fraud, but they are not superior to the other methods. The inconveniences are of two orders: The physiological effects of injections present nothing special, as they are found in all the methods—salivation, digestive troubles, debility. The special inconveniences of the method are more serious: the injections are painful; the pain is of two sorts. There is, in the first place, the pain caused by the prick by the needle; it is true that it is slight, but it exists. Then is produced a consecutive pain after the injection. It commences a little after the operation, increases during ten or twenty minutes and then diminishes. Sometimes it lasts three, four, five, and six hours. Consecutively to the injection there is produced a pain in the region which becomes hyperesthetic. These accidents vary according to the formula of the solutions and the susceptibility of the patients. It was said that corrosive sublimate dissolved in the serum of sterilized blood was completely painless. Dr. Hallowpean, who employed this solution, established that it caused the most atrocious pains. The mercurial injections are sufficiently painful for patients to refuse to submit to them. The author was told by Dr. Besnier, one of the physicians to the St.

Louis Hospital, that when a medical man employed injections his ward was soon deserted. Frequently after the injections there are produced tumors resembling those of erythematous nodosities or a small lipomata. They are of the size of a chestnut, and even of a large fowl's egg. They may persist during three or four months, but they are resolved on an average at the end of from three to four weeks. They are indolent in themselves, but they cause great annoyance. The patients can not sit, and have great difficulty in walking. Sometimes they get inflamed and give rise to abscesses which open spontaneously, or the surgeon is obliged to incise them. It has been observed, after the injections, that sphacelus and cutaneous gangrene have occurred. These accidents are now more rare, but it is well to remember that they may be produced. Dr. Fournier concluded his lecture by the following remarks: (1) As much as possible, one must spare the patients the inconveniences of injections. (2) These have only precise and formal indications, which are three in number. In the first place, in the cases where the other methods have failed, they are frequent, they cause intolerance of the digestive passages, the necessity for respecting these passages when they ought to be left free for the administration of other medicaments, the cases where the skin does not well support frictions, finally, cases where rapid mercurialization is necessary. Certain fortunate cases have been cited. The method is rational in principle, but we do not possess sufficient documentary evidence to conclude.

According to Prof. Verneuil, furunculosis is a microbial malady which is propagated by contagion. The malady is due to the presence of a microbe to which has been given the name of "golden staphylococcus." One can then easily comprehend the successive appearance of several boils in the neighborhood of the first. One can also understand how they may extend to a distance by scratching, which produces a veritable inoculation of the microbe under the epidermis. It results, from this microb-

ian origin, that the antiseptic medicaments are without doubt the surest means of cure, on the condition, nevertheless, that the malady is not of ancient date. A very concentrated solution of boric acid, in hot water or in alcohol, succeeds perfectly in the majority of cases in aborting the boils.

At the Salpêtrière Asylum, Prof. Charcot delivered a very interesting lecture on a variety of epilepsy in which the patient suddenly loses consciousness of his actions, and starts off on a walk without knowing where he is going. These accesses may last ten days. He exhibited a patient who, after having made numerous excursions in Paris, started on the 18th January, about 7 in the evening, in an access of ambulatory automatism ("*automatisme ambulatoire*"), and walked thus for ten days. When he awoke he was on a bridge in a town which he did not know. It was in Brest, where he had arrived during his access. M. Charcot also cited an example of an analogous case which declared itself after a fall. It was that of a porter who was epileptic, and who, after this accident, was seized with a similar access, and traveled during eight days without stopping and without consciousness.

In the *Avenir Medical* is published a note from Dr. Pampoukis, of Athens, who observed that animals are equally subject to seasickness, and that the displacements of the animal (translation and rotation) exercise considerable influence on the abdominal viscera. Notwithstanding the attachments constituted by the peritoneum, these are put in motion and strike against the walls of the abdominal cavity, particularly against the diaphragm and the anterior wall. The means that may be employed to limit the movements, such as the compression of the abdomen by bands or straps of different species, restrain the shocks against the abdominal wall, but they are in a great measure continued against the diaphragm.

Dr. Bertherand, of Algiers, has published an interesting note on the influence of tobacco on pregnancy and the genito-urinary

organs. According to the author, women working in tobacco manufactories menstruate very irregularly, and sometimes not at all. Metrorrhagia is frequent in women who become pregnant. In fine, all the women and girls who work in these manufactories are in an anemic state which is very characteristic.

PARIS, March 15, 1889.

### Translations.

UNDER THE CHARGE OF I. N. BLOOM, A. B., M. D., DERMATOLOGIST TO LOUISVILLE CITY HOSPITAL, ETC.

**SUSPENSION OF ANIMATION AMONG THE FAKIRS OF INDIA.**—(*Journal de Médecine*, February 7, 1889.) This short feuilleton is interesting in that it describes the preparations which the fakirs make before "hibernating." They begin by practicing suspension of respiration, and are able to do this from five to twenty minutes, and longer. They then wash out the intestinal tract completely from one end to the other. The sublingual muscle is cut so that the tongue may be rolled back so as to completely cover the larynx. These are all the preparations made by the fakir. Dr. Honigberger witnessed the burial of the fakir, Harides, and thus describes it. On the appointed day, in the presence of the rajah and a large number of witnesses, the fakir seats himself on a linen sheet; he fixes his eyes on the extremity of his nose, and in a few moments is in a state of cataleptic hypnosis; the eyes are closed and the extremities become rigid. The assistants of the fakir close the ears and nostrils with lint and wax. The body is wrapped in the sheet, which is knotted and sealed with the seal of the rajah, and placed in a wooden box similarly sealed. The box was placed in a grave-like pit, which it completely filled, and the lid was fastened and sealed, the grave filled up, and the place was watched night and day.

At the end of six weeks the fakir was exhumed and the rajah found the seals intact. The shroud was covered with moisture just as is any linen exposed to humidity. Dr. Honigberger examined the body of the

fakir. The arms and legs were wrinkled and rigid. The radial and temporal pulse could not be felt, nor could any heart sounds be detected. The whole body was cold. During all this time the assistants bathed the body with warm water and rubbed the extremities. Upon the head they placed a layer of warm wheat paste, and renewed it several times. The wax tampons were then taken from the nose and ears, and finally one of the assistants opened the fakir's mouth with a knife, pulled the tongue into place, and insufflated air into the lungs. The eyelids were raised after having been rubbed with warm grease. The eye was glassy in appearance. At the third application of the warm paste to the head, the fakir trembled, the nostrils dilated, the pulse beat feebly, the limbs grew warmer, and the eyes regained their luster. The fakir, returned to life, said to the rajah, "Do you believe me now?" At the end of an hour the fakir, still very feeble, was seated at the royal table.

On another occasion Harides was buried for four months, and resuscitated with the same success. Similar cases have been reported from time to time, and it is impossible to doubt their genuineness. If we can not explain these cases, we can find a host of analogous facts in the lower animal life, as for instance, the hibernation of dormice and other animals, the revivification of fish and frogs after a winter passed in ice, the vital resistance of toads and other living beings inclosed without nourishment for many years in small, hollow places, etc.

**A DISCUSSION ON KELOID.**—(*Society of Physicians, of Munich. Muench. Med. Woch.*, No. 6, 1889.) Dr. Seidel exhibited a case of multiple idiopathic keloid. The patient was a man, twenty-eight years old, who had never been ill, never had syphilis or tuberculosis, whose parents were alive and enjoying robust health. No one in the family had ever suffered from neoplasms. Six years ago the tumor began on the chest, and was as large as a bean when first observed; it grew slowly and steadily until at this time it was

as large as a man's hand. Three years ago a second keloid appeared somewhat lower down, and one year ago another appeared on the left shoulder, and another on right upper arm. The keloid in these latter places seems to be entirely superficial, and is composed of several nodules which have become confluent. It possesses numerous projections which run into the healthy tissue. The large number of acne pustules and comedones is striking, creating the impression that the cicatrices from these might have been the primary cause of the neoplasm.

The speaker referred to the inefficacy of the various forms of treatment, but thought that the subcutaneous injection of ergotin, as recommended by Reh, had diminished the size of the tumors presented.

Professor Angerer reported three cases of keloid which he had observed. Two of them were cicatricial keloids following extensive burns, the other a so-called spontaneous keloid. In the latter case, a girl, fourteen years old, the neoplasm formed at the site of vaccination. The rest of the body was free, but, as the keloid occupied the exact spot where the patient had been vaccinated, it was plainly a cicatricial keloid.

The prognosis of operative procedure for keloid is very bad; they all return. In two cases the speaker had extirpated the new growths, and union by first intention followed, but a week after the cicatrix became reddened and somewhat elevated, and several weeks later the keloid had returned in its entity. In another case a keloid followed an extensive burn on the shoulder and breast, and the head of the patient was drawn to one side. Angerer did a plastic operation after extirpation of the tumor. The case did well at first, but after a time the patient returned with the same disability, the keloid having formed again.

He can give no information as to the cause of keloid, especially of the true idiopathic keloid.

Professor Ziemssen can recall no case of true keloid; all those which he had seen were the result of some destructive process,

such as burns, syphilitic ulcerations, etc. Syphilitic ulcers tend to the formation of hypertrophic cicatrices, just as do burns. This happens with especial frequency, but on a small scale with acne cicatrices and those following cupping.

Professor Kerschensteiner has had the opportunity of observing a characteristic keloid for eleven years. The patient was a very fat woman who, as a girl of fifteen or sixteen, had first noticed it as a claw-shaped elevation, small in size, situated on the sternum. This grew slowly until with its projections it involved both mammæ. No inherited disposition or traumatic cause could be discovered. It was a true idiopathic keloid. The tumor was at one time pale, at another red, and had the consistency of erectile tissue, yet at no time resembled a nevus or telangiectasia.

Professor Braun had seen two cases of keloid which followed attempts to remove pigment spots with lunar caustic; they were extirpated by Professor Helferich, yet returned three months later.

The constant application of ice-bags finally brought about improvement.

**POMADE FOR THE PRESERVATION OF THE HANDS OF SURGEONS.**—(*Journal de Médecine*, February 10, 1889.) Surgeons know that antiseptics have the inconvenience of hardening the hands and often causing desquamation of the epidermis. Liebreich recommends either of the following pomades:

Lanoline, 50; vanilline, 0.10; essence of rose, gtt.i, or lanoline, 100; liquid paraffine, 25; vanilline, 0.10; essence of rose, gtt.i.

Wash the hands thoroughly, grease lightly with either of the above; after this, they may be dipped freely into antiseptic solutions without injury.

**SYPHILITIC AFFECTIONS OF THE KIDNEY.** Carmelo Andronico (*L'osservatore*, December, 1888) has given the following as the result of his observation and research into the literature of the subject: (1) They may occur in congenital as well as in acquired syphilis. (2) From a clinical stand-

point they present various forms, from a simple nephritis to the interstitial or gum-mous. (3) They can not be differentiated from other nephritic diseases either by the *ensemble* of symptoms or the pathological anatomical characteristics. (4) The gum-mous form is an exception, because it presents a specific neoplasm with special anatomical peculiarities. (5) Although syphilo-nephritic diseases occur in the later periods of infection, the gum-mous forms do not. (6) The cure of syphilitic affections of the kidney is relatively easy, and is a certain proof of the diagnosis. (7) The only rational treatment is the mixed treatment, and mercury is an essential. — *Deutsche Med. Zeit., February, 1889.*

### Abstracts and Selections.

THE RELATIONSHIP BETWEEN NEURALGIA AND ABORTION: A CLINICO-SPECULATIVE NOTE.—Reflex neural disturbances is confessedly a difficult subject to handle judiciously. The term "reflex causes," like our familiar and much-abused friends "dyspepsia" and "febricula," is in great measure simply a wide and unexplored scientific desert, in which the barren sands of speculations, uncertain and indefinite, are immeasurably more plentiful than the grateful and refreshing wells of sparkling precision or the comforting oases of confident opinion. How to clearly understand reflex neuroses, how to estimate their force and import, is still an unsettled problem of our modern medicine. If we, as obstetricians, accept, even in a restricted sense, the dictum of Marshall Hall, "the whole question of abortion and parturition, and, in a word, of obstetrics as a science, is one of the true spinal system," surely it behooves us to devote renewed attention to so important a theme. In a former communication to this society I touched upon reflex paralysis in connection with puerperal albuminuria; in the subsequent valuable discussion doubts were suggested by one or more of the speakers with reference to the risks I encountered when I ventured on "the dangerous ground" of reflex paralysis. Other speakers, notably Surgeon-Major Arnot, who spoke with reference to practice in India, referred to several cases of convulsions which seemed solely due to mere irritation of the nervous system. The purport of the present paper is to deal only with that form of neurotic affection which is called neuralgia.

Many years ago it was shown by Tyler Smith that irritation of the excitor nerves and of the spinal centers formed the two classes, excentric and centric causes of abortion. He thought that irritation of the extremities of the excitor nerves, as, for example, irritation of the mammary nerves (what he referred to as the "synergic relations between the mamma and the uterus"), and which he seemed to regard as wholly peripheral, was due to some peculiar and direct sympathy. He remarked "that gastric irritation had no effect in producing abortion," nor was "the most extensive lung disease accountable," although "the synergies between the lungs and uterus were remarkable." He admitted that irritation of the trifacial was an occasional cause, and that sometimes when no other explanation than the appearance of the wisdom teeth was the local detriment. Vesical irritation from calculi or chronic inflammation was also mentioned. Rectal nerve irritation is "a common cause of abortion," according to the same writer; as also is vaginal nerve and ovarian nerve irritation. I am not disposed to accept the entire truth of these observations; yet there are no grounds for disputing Smith's influence on the subject as being distinctly helpful to those who have read his unquestionably meritorious and original ideas. He further states, "Irritation of the uterine nerves is beyond doubt the most important of all the causes of abortion; and all these causes, whether vaginal, mammary, vesical, rectal, facial, or uterine, are purely excitor-motor in their operation. The irritation is applied to the excitor nerves, and reflected through the spinal marrow upon the motor nerves and uterus."

Modern physiology has determined certain definite groups of nerves with distinct functions, which, so far as they now concern us, may be mentioned: (1) The centrifugally conducting nerves, motor nerves for the smooth muscles, usually involuntary, with secretory, trophic, inhibitory, and vaso-dilator nerves; (2) the centripetally conducting nerves of excito-motor or reflex function. We recognize the fact that the nerves entering the uterine mucous membrane are connected with ganglia. In normal gestation there is a state of neurotic impressibility which manifests itself at times by uncertainty of temper or sleeplessness, by perversions of taste or smell, by sickness, by amblyopia, hemeralopia, vertigo, syncope, hyperesthesia, or attacks of neuralgia. It is, of course, debatable whether these symptoms are due to reflex causes in consequence of the changed conditions in the sexual organs, or to the leucocythemia of pregnancy and the consequent results.

While there is generally heightened nervous susceptibility, there is uterine resistance to impressions, or, in other words, increased nervous inhibition to a markedly great degree. And this action, although imperfectly understood, is not one of abeyance of excito-motor action and interruption to the consequence of reflex sensations. The theory has formally been suggested that there is "an independence and seclusion of the nervi-motor apparatus of ovi-expulsion until the appearance of the exciting causes of labor." While we admit the existence of distinct centers for uterine action, it is difficult to follow a theory which postulates that the presence of an embryo of varying size and relation to the uterus can produce a local blocking of reflex impressions. During and immediately after parturition the spinal centers distinctly control the uterus, yet it is argued that "during pregnancy no reflex action sufficient to cause abortion will follow immediately upon the application of the ordinary stimuli of excito-motor action." Now all through pregnancy, very markedly during the latter months, there are very distinct uterine contractions due to reflex impressions; but it is contended that "it is necessary that the nervous arcs in relation with the uterus must be continuously irritated for a considerable time ere reflex occurs." Admitting that time is, after all, only a relative term, we may broadly deny the necessity for a prolonged irritation. Emotions, as anger, fear, joy, etc., which have lasted for only a very short time, are clinically admitted causes of abortion.

It may best serve our purpose to leave for the present the theoretical, and regard certain practical and clinical facts. Let us recall the nervous supply of the uterus, and we will note that in continuance with and from the great splanchnic we have the aortic plexus, which divides into branches, giving rise to the inferior hypogastric, from which we have uterine and vaginal branches, and the aortic plexus terminating in the hypogastric, which originates the uterine and ovarian plexuses. The hypogastric is also in close connection with four lumbar ganglia; and also in descent from the aortic plexus we have directly the inferior mesenterics; so that it is easy to realize how many and important direct results may be due to disturbance of the reflex nerve supply.

Neuralgia of cranial and spinal nerves is very often associated with abortion. The trifacial, the occipital, the brachial, intercostals, the sciatic, and the pneumogastric are not uncommonly affected.

One of my patients, who had aborted very frequently, before abortion had always a sharp neuralgic attack, principally affecting the lach-

rimal and frontal branches of the fifth, and running down the cervical plexus to about the middle of the neck. She had in addition considerable gastric pain, with a tendency to flatulent eructations. In this case the neuralgia of the head and neck invariably preceded uterine action, and at no other times was this lady a sufferer from neuralgia. Another patient, who was never previously neuralgic, was, during the sixth month of her first pregnancy, attacked with severe gastralgia with nausea, but had no vomiting. Fetal movements became feeble, very acute neuralgia of one side of the face and neck supervened, and seven days from the onset of painful symptoms she was prematurely delivered of a dead child. Another case had neuralgia confined to the intercostals and brachial of one side in two successive pregnancies; abortion took place at three months in the first, and was averted in the second. A fourth lady had acute neuralgia of the face and down one arm, with distinct uterine contractions resulting, at each period for the first six months of her first pregnancy. I might give many other cases, but will rather state my experience aphoristically.

1. Neuralgia and abortion are frequently associated.

2. In certain cases of "habitual abortion" neuralgia invariably manifests itself as the first symptom, attacking cranial or spinal nerves remote from the uterus.

3. If treatment relieves the pain, there is a strong probability that uterine disturbance will not commence, or, if already there have been contraction, these will cease.

4. Neuralgia, while perhaps the most common in the rheumatic, occurs in different types of patients: In the anemic, dyspeptic, or malnourished, or in the overfed, indolent, and plethoric.

5. Fetal death is sometimes the evident cause; sometimes it evidently results from the reflex irritation associated with the neuralgic pain.

6. Acute neuralgias occurring in pregnancy may not in any way interrupt healthy gestation.

7. When severe facial, cervical, or other neuralgia yields to treatment, even though the embryo is dead, uterine contractions and emptying will not occur for days, perhaps weeks.

8. The trifacial, occipital, and cervical nerves are most commonly affected; but brachial, intercostal, lumbar, and sciatic neuralgias are also met with.

9. Acute gastric irritation is associated with neuralgia and abortion. Pregnancy sickness, although very severe, but seldom causes miscarriage; but gastrodynia, which is sometimes

accompanied by salivation and a constant feeling of nausea and depression, not infrequently precedes acute neuralgia, which eventually causes uterine irritation, and ends in abortion.

The neuralgias of the sciatic may be rheumatic or due to pressure or other purely local causes, and the latter will specially apply to rectal and vesical neuralgia. Ovarian neuralgia is, in my experience, a very common condition in aborting women, and I believe accounts for many unexplained cases; yet we can hardly separate ovarian from uterine irritation as distinct conditions during gestation. Some cases, indeed, admit of easy discrimination. One patient, who threatened to abort at the second, third, and fourth months, was on each occasion treated by bromides, and a blister applied over the left ovarian region, which was markedly tender, and she carried her child to term.

She had previously miscarried twice with similar symptoms. It has, however, been said that "physical irritation of excitor surfaces short of pain or sensation may produce the entire phenomena of abortion." This is possibly true, but not very probable. As a supplementary observation, I would add that painful sensations remote from the uterus not infrequently originate abortion.

I have said nothing of neuralgia from dental caries; for, although dental caries is so common in pregnancy, and although neuralgia very frequently results, I have never known abortion follow this form of neuralgia. Toothache in pregnancy should be treated on general principles. I have never seen ill effects follow tooth extraction in pregnancy. I have always advised the exhibition of nitrous oxide or chloroform for such operations, or else, failing the suitability of anesthesia, have ordered applications of local sedatives, as camphor and chloral, or chloroform, to be used as temporary measures until after parturition.

The fact is, that neuralgias due to peripheral irritation, such as a decayed tooth or bladder concretion, or rectal hemorrhoids or growths, seem to be much less important than neuralgias associated with general constitutional states which have no available local explanation. The shocks of grave operations, for example, ovariectomy and herniotomy, etc., have been undergone during pregnancy without the least indication of uterine disturbance.

In neuralgia which precedes abortion we have a certain periodicity, a recurrence marked by such regularity in some cases that there seems to be a suggested special or peculiar cause. I do not recollect any connection with distinct or even slight ague; but although there are no clinical symptoms of malaria further than the periodicity, we have to remem-

ber that we have not only a condition of hydre-mia, but, according to Virchow, a "physiological leucocythemia of the blood" and this in connection with splenic enlargement, more or less permanent, in normal gestation. We have flushings, sweats, and chills; we have temporary albuminuria, temporary glycosuria—all by no means rare manifestations of puerperly.

But there must be, there is, a distinctly different pathological consideration forced upon us: Why do these conditions cause no interference with some cases and prove very prejudicial in others? Are the theories of reflex action or of blood deterioration the more important? Are there no other possible explanations? Is it permissible to suggest that, as in certain organic neuroses causing loss of speech, sight, taste, smell, and locomotion, and as in some of these, in which only certain limited areas of cerebral or spinal surface are affected, we have only very partial irritations or paralysis, there may be, in like manner, as a consequence of the general perversion of pregnancy, actual limited organic paralysis as well as increased excito-motor sensibility? Push this argument a step further. As we have increased body weight (quite beyond the uterine burden), enlargement of heart, blood-vessels, liver, glands, kidneys, etc., why deny the possible production of increased multiplication and enlargement of neuroglia and nervous tissue generally? As we have traced the uterine nerve supply to the splanchnic, so might we proceed upward through the whole chain of sympathetic ganglia till we reached the upper cervical ganglia with its internal brain and spinal connections. And if, in consequence of an undue accumulation of neuroglia cells, possibly from an exaggeration of the normal blood of pregnancy, or again from the fibroid changes of rheumatism, or from the sometimes exceedingly obscure lesions of neural syphilis, we had an interruption to the perfect conveyance of nervous impressions, and probably a condition of "blocked nerve impulses," it would not be difficult to realize that, should any untoward circumstance arise, irregular reflex disturbances would be apt to occur.

The deduction therefore is, that there are two sets of nerve affections in pregnancy: (1) those of simple localized peripheral origin, as neuralgia from dental caries, from vesical, rectal, or pelvic pressure, which seldom go on to cause uterine neuralgia of such degree as will end in contractions sufficient to cause premature expulsion of the embryo; and (2) neuroses which owe their origin to general conditions of constitutional disturbance, and which may manifest themselves by appearing as acute neuralgia of cranial or spinal nerves.

In the latter class the inhibitory action will sooner or later be gravely affected, and the normal excito-motor conditions will speedily involve the organ upon which physiological action has exercised its paramount influence; that is to say, a patient suffering, for example, from chronic rheumatism, will be apt to abort not only from chronic rheumatic endometritis, but from the central neural disturbance due to the blood deterioration. Neuralgia occurring in such a case may be facial or intercostal, but speedily becomes uterine, not from peripheral, but from central causes of irritation. A few hours after the commencement of an acute rheumatic neuralgia in the head and neck, sharp ovarian and uterine irritation is experienced; contractions at first spasmodic, and then regular, sharp, and in muscular waves, accompanied by hemorrhagic effusions, may very shortly terminate the pregnancy.

I have found that the successful control of neuralgia in pregnancy demands attention to one or two points. If the patient is anemic, quinine given alone in ten-grain doses twice daily, or, still better, with a grain of opium with each dose, is best as an immediate sedative, and free doses of arsenical solution are most useful as inter-attack treatment. But when the patient is plethoric, especially if there is a gouty or rheumatic tendency, chloride of ammonium, ten to fifteen grains every two, three, or four hours, with bromides of ammonium or sodium, opium, and aconite, or with veratrum, will answer best. *Viburnum prunifolium* is of the greatest value in some cases, and certainly ought to be given as soon as the uterine pains are felt. The liq. *caulophyllum et pulsatillæ com.* promises to prove valuable as a uterine and ovarian sedative, and might be given either alone, or with *viburnum* in lessened doses, as soon as acute pain has subsided. Other patients will do well with antipyrin, fifteen grains every two or three hours, or iodides and alkalies; and for some I conceive a course of baths at Kissingen, Kreuznach, Ems, or Wiesbaden will do more good than any drug. But we must act promptly and dose liberally during the acute attack of neuralgia. — *Dr. L. Napier, Edinburgh Medical Journal.*

**FRACTURE OF THE OLECRANON TREATED BY ASPIRATION.**—In Mr. C. Heath's clinical lecture on Fracture of the Lower Extremity, he condemns putting up a fracture of the olecranon in the extended position, owing to a subsequent liability to stiffness in this position. As he does not mention aspiration of the elbow-joint, and I find no mention of it in any of the well-known books

of surgery within my reach, the following case might induce others to try the same treatment as I did, and with equally good results. As this is the only case of the kind I have had under my care during the last year, of course I can not say in what percentage of cases we might hope for similar success.

A boy, aged nineteen, fell through a trap-door a distance of twelve feet, coming down on his right elbow on a brick floor. I saw him about fifteen minutes afterward, and found a transverse fracture of the olecranon, with about three quarters of an inch separation of the fragments, and the joint distended and bruised. I immediately aspirated the joint by introducing the needle between the two fragments, and drew off between two and three drams of nearly pure blood. I covered the wound with a piece of blue wool, and surrounded the joint and the arm below and above it with a thick layer of absorbent wool, putting an extra quantity at the bend of the elbow to prevent full extension on applying the straight splint in front. The arm and elbow were then firmly bandaged to the splint in the usual way. I may say that the fragments came into apposition after the aspiration. He was kept in bed with his arm lying on a pillow for three weeks, and when it was examined at the end of that time the fragments were united by a ridge of callus, and he could bear slight flexion without pain. The arm was left straight for another ten days, when a sling round the neck was substituted and his elbow flexed. For the next ten days the joint was passively flexed every day, and when shown at a medical meeting at the end of the seventh week there was firm bony union, a ring of callus marking the seat of fracture; he had perfect movement, and went to work in a warehouse in another week.

I am quite aware that due allowance must be made for the rest in bed in this case, as I have seen a case treated in bed without aspiration recover with firm bony union, but with stiffness that lasted very much longer than in this one; and if aspiration overcomes this difficulty — and aspiration with an aseptic needle can not possibly do any harm — a great point will be gained. Mr. Heath says: "An elbow-joint which has fractured olecranon is certainly liable to inflammation; there is always effusion in it." And as it is well known that tension is the chief cause of inflammation, and inflammation the cause of subsequent stiffness, it follows that aspiration, followed by firm elastic pressure and

perfect rest, will give us the greatest chance of a movable joint with firm bony union, and three weeks in bed is well spent if we can make sure of the latter in the greater number of cases so treated.—*Mr. F. W. Jollye, London Lancet.*

**THE INFLUENCE OF BITTERS ON THE DIGESTION AND ASSIMILATION OF ALBUMINOID MATTERS.**—Some experiments made by Leven go to show that the ordinary bitters (extracts of cinchona, quassia amara, nux vomica, gentian, etc.) promote for a time digestion and assimilation; they are, however, soon followed by loss of appetite and dyspeptic troubles. According to Leven's interpretation, these medicaments excite the solar plexus and energize the activity of the gastric glands and muscular movements, but soon produce by exhaustion a diminution of this activity and an irritated and congested state of the gastric mucous membrane.

Several years ago Buchheim and Engel undertook a series of experiments to ascertain the influence of bitter substances on digestion, and concluded that "these substances have no action on the transformation of albumen into peptone, and they oppose fermentation." It is by virtue of this property, according to these physiologists, that bitters act so favorably in certain diseases of the digestive tube.

Since then Tschelzoff, chief of Prof. Botkin's clinic, has taken up anew this interesting question of the influence of bitters on digestion and on the nutrition of the animal organism in general. His conclusions are, "that extracts of the so-called pure bitters, which are usually prescribed with the view of stimulating the secretion of gastric juice and of aiding digestion, so far from having any beneficial action of that kind, are absolutely injurious, in that they retard the digestive functions." He experimented with extracts of aurantium, gentian, trifolium, absinthium, calumba, cascarrilla, and quassia, on (1) gastric digestion and the secretion of gastric juice; (2) pancreatic digestion and the secretion of pancreatic juice; (3) the secretion of bile; (4) fermentation; and (5) nitrogenous metamorphosis. He arrived at the conclusion that bitter extracts, even in small doses, interfere with artificial gastric digestion, and also with gastric digestion of animals, but not to so great an extent. Large doses of bitter extracts diminish the secretion of gastric juice, although small doses effect a slight and transitory increase of it, the digestive power of the fluid being, however, in all cases diminished. Bitter extracts have no effect on the secretion of pancreatic fluid, but they nevertheless retard hypogastric digestion.

The action of bitter extracts on the secretion of bile is various. Extract of absinthium, extract of trifolium, and large doses of extract cetrarin slightly increase it, while extract of quassia, extract of calumba, and small doses of extract cetrarin have no effect at all. Bitter extracts have no antifermentative effect, but rather hasten and promote fermentation, especially in large doses. The putrefaction of blood and urine is favored by the presence of pure bitters. With regard to the effect of bitters on nitrogenous metamorphoses, the Russian experimenter found that under their influence the quantity of waste nitrogen in the urine and feces was increased; in other words, dissimilation was accelerated, while on the other hand assimilation was diminished.

It would seem from these experiments that bitters are of very questionable utility in the treatment of digestive disorders. It will not do, however, to adopt this conclusion without considerable reservation. Experiments made in test-tubes in the laboratory and experiments on animals should not be allowed to outweigh the results of clinical observation; and, to quote the words of Lauder Brunton, "the evidence of clinical experience in regard to the utility of bitter extracts is so strong that it is plain, either that the experiments have been imperfectly conducted, or that we must look to some other organ than the stomach for an explanation of the beneficial action of bitters in dyspepsia."—*Boston Medical and Surgical Journal.*

**HEMORRHAGE IN SALICYLISM.**—In Guy's Hospital Reports, 1886-'87, Dr. Shaw reported two cases in which the administration of salicylate of soda and salicin in rheumatism was followed by hemorrhages; in one case from the nose and into the vitreous chamber, the patient recovering with the loss of sight in the eye; in the other case from the kidneys, resulting in death. In the *Lancet*, January 19, 1889, he reports two more cases occurring in the hospital in which hemorrhages occurred under the administration of salicylate of soda and salicin (both of the drugs seemed to cause this symptom). In one of these cases now reported, the patient suffered from her first attack of rheumatism, and salicylate of soda was given in doses of twenty grains every three hours for four days, then every six hours for four days, then three times a day for three days. At this time bleeding from the nose and more profusely from the gums began. The salicylate was stopped, and the hemorrhage ceased four days later. About a week after this a return of the articular pain was felt, and ten grains were given three times a day. Next day bleeding

from the gums began. This ceased soon after the drug was discontinued. The patient recovered. The second case resembled that just described, the amount of salicylate given being about the same. The bleeding was from the gums only, and recurred shortly after an increase in the dose of the drug, but the patient recovered. In commenting upon the cases which he has recorded, Dr. Shaw gives good reason to believe that the bleeding not only followed the use of the salicylate, but resulted from it. None of the patients were "bleeders," and in each case the hemorrhages occurred after the rheumatism had begun to subside. Although he has carefully observed all cases which have come to his notice, he has never seen hemorrhage of any sort occur until several hours or days after signs of salicylate poisoning—deafness, vomiting, ringing in the ears, headache, and irregular, slow pulse—have appeared.—*Maryland Med. Journal*.

**A CAUSE OF NASAL OBSTRUCTION.**—If an anterior rhinoscopic examination of the nose be made, it will be observed that at the junction of the skin lining the vestibule with the mucous membrane lining the anterior nares there is a projecting band of tissue running from above, backward and downward, along the outer wall of the cavity. If now the patient be directed to inspire strongly or to sniff, it will be found that this band will, at each inspiratory act, approach toward the septum of the nose so as to considerably narrow the air-passage. This band corresponds with the junction between the lower lateral cartilage of the nose and the bony margin of the anterior nares, and its position is marked externally by the depression usually seen immediately above the lower expanded part of the nose.

My attention was recently attracted to this band as a cause of nasal obstruction by observing a case in which expiration through the nose was easily performed, but in which, at each inspiration, the alæ nasi fell in to such an extent that the bands above referred to came in contact with the septum and acted as a complete valve. This patient had all the usual symptoms of nasal obstruction, but examination of the nose and naso-pharynx failed to discover any further cause of obstruction, and, indeed, it was evident that none other existed, for when the anterior nares were held open by a speculum, or by drawing the alæ nasi away from the middle line with the finger, inspiration was performed with the greatest ease.

This band can be seen more or less well marked in perfectly normal noses, but in such it produces no impediment to inspiration, as it

is sufficiently far away from the septum. But in a nose in which the alæ nasi do not stand out as prominently as they should (and this we frequently see in adults as the effect of post-nasal growths in childhood), the alæ nasi fall in at each inspiration, and this band and the septum come into apposition so as to completely block the nose. The same result may be seen in cases where the anterior part of the septum deviates even slightly to one side.

I believe that this cause of nasal obstruction is usually overlooked, because the introduction of a nasal speculum, which is usually the first thing done in a rhinoscopic examination, hides the band from view, and, at the same time, prevents it from falling in during inspiration and producing its obstructing effect.

I have not yet had the opportunity of observing the effects of treatment in this condition, but I think that the introduction of two hollow vulcanite tubes into the anterior nares at night would hold the passage open, and so prevent the dry mouth, etc., so commonly complained of in the morning, and at the same time dilate the apertures so that in time the bands referred to would be sufficiently removed from the septum to cease to do any harm.—*Dr. Edmund Roughton, British Medical Journal*.

**A CONTRA-INDICATION OF ANTIPYRIN.**—Antipyrin, among its other properties, exerts a hemostatic effect, which, according to Dr. Huchard, may be productive of serious results if incautiously given during a menstrual period. He mentions the case of a woman suffering from severe dysmenorrhea, for whom he ordered 16 grains of the drug, with the effect of immediately suspending the flow. The arrest was accompanied by shivering and cyanosis and a tendency to syncope. These symptoms caused him a great deal of anxiety for half an hour, when they gradually passed off. He has noticed the same effect, but less marked, in two other cases in which he had prescribed the drug under similar circumstances.—*London Medical Press*.

**CHOREA AND RHEUMATISM.**—I think the following case may be of interest as throwing some light on the pathology of chorea in connection with rheumatism, especially after the recent discussion at the Medical Society of London on this very interesting question.

On January 12th I saw E. M., aged fourteen. Both her knees were swollen and tender; she seemed in considerable pain, and her general symptoms pointed unmistakably to acute rheumatism. The heart's

action was a little excited, but there was no evidence of any endocardial lesion. She was only just recovering from an attack of quinsy. Under salicylate of soda the arthritic symptoms rapidly subsided, and I was in hopes of a speedy convalescence.

On January 18th well-marked choreic symptoms made their appearance, but every trace of joint affection had gone, and, on careful examination of the heart, no sign of disease could be elicited there, although I auscultated with a strong impression that some valvular lesion ought to be present.

January 21st. Chorea about the same. Again I carefully examined the heart, with negative result. Temperature normal.

January 23d. Chorea movements seem to be lessening. There is now a distinct mitral systolic *bruit*, short and somewhat low-pitched. From this time up till February 1st the chorea became gradually worse. On that date she was removed to the London Hospital, and now lies in Rachel ward under the care of Dr. Fenwick, the only change in the cardiac signs while under my care being that the *bruit* became somewhat longer in duration and of a higher pitch.

There seem to me to be two points of special interest about this case: (1) The immediate sequence of quinsy, acute rheumatism, and chorea; (2) the manifestation of the chorea symptoms before any evidence of cardiac affection could be discovered.

With regard to family history, I may say that the mother and an elder sister have had repeated attacks of quinsy, for which I have attended them.—*Dr. Major Greenwood, British Medical Journal.*

**TREATMENT OF INGROWING TOE-NAIL.**—Dr. Theodor Clemens, of Frankfort, strongly recommends the employment of tinfoil in the treatment of ingrowing toe-nail. He first has the toe thoroughly washed with soap and carefully dried. He then envelops the whole nail with tinfoil, putting a strip between the portion that grows in and the raw surface caused by it. The tinfoil is fixed by means of a very thin layer of common wax, and the patient is told not to wash the part, but to use dry bran for rubbing off the dirt. Of course, the toe has to be repeatedly dressed with tinfoil; but, if the operation is carefully performed, it is surprising how long the tinfoil will remain intact, even when the patient is, as was usually the case in Dr. Clemens' hospital practice, very poor and very badly shod. The results are stated to have been most satisfactory, and are ascribed by Dr. Clemens, not merely to the

mechanical action of the tinfoil, but to the effect of the permanent contact of a combination of metals comprising iron, copper, arsenic, molybdenum, wolfram, and bismuth, with a moist and growing portion of flesh. This, he says, brings about in a few weeks the complete healing of the sore, and causes the nail to grow more slowly and in a more healthy manner.—*London Lancet.*

**EXTIRPATION OF TUMORS OF THE BLADDER.** The general adoption of the operation of supra-pubic cystotomy in Europe has led to much more frequent attempts to remove tumors of the bladder than were made a few years ago, when only the difficult and uncertain route through the perineum was open to surgeons. At present no tumor is permitted to make serious advances or to do serious harm to a patient under the observation of a surgeon without an effort to remove it; and nowhere is this more true than in Paris, where the supra-pubic operation is practiced almost to the exclusion of other methods.

An illustration of the scope of this operation is furnished by a case described in a recent lecture by Dr. Bazy, at the Hôpital Beaujon, which is reported in the *Bulletin Médical*, January 16, 1889. In this case, after the usual history of a papilloma of the bladder, the patient came under the care of Dr. Bazy, who opened the bladder from above the pubes, and removed a tumor about two and one half inches in diameter, situated on the right side of the bladder and encroaching a little upon the *bas-fond*. After describing the operation—in which he unwittingly cut off the lower end of the right ureter—Dr. Bazy states his opinion that excision of tumor of the bladder is preferable to enucleation, or scraping, or cauterization. Total ablation is, he thinks, the only way of dealing with these new growths, and that this should be practiced as early as possible and made as thorough as possible. The line of excision, he says, should pass through the healthy mucous membrane, and it may even include the opening of one or both ureters, if necessary. In case this is necessary, he thinks the stump of the ureter should be attached to an opening in the bladder wall made to receive it. Of course, in such an operation the wound in the bladder and abdominal wall should not be entirely closed, and a suitable drainage tube should be left in the bladder.

These views are radical, but we believe entirely sound. Tumors of the bladder are dangerous, not only on account of their

local and immediate effects, but also on account of their influence upon the kidneys and their proneness to recurrence. It is rational to remove them, as Dr. Bazy advises, as early and as thoroughly as possible, and we think he makes a good point when he prefers excision to the easier methods of scraping or cauterization.—*Medical and Surgical Reporter.*

**THE SUSPENSION TREATMENT OF LOCOMOTOR ATAXIA.**—The first case treated in England on the plan described in our issue of February 6th is one at present in St. Mary's Hospital, under the care of Dr. de Wailleville, physician in charge of the electrotherapeutic department of the hospital, who began a course of suspensions the same day that Professor Charcot's article reached London. He has since taken two other cases in hand, and the results have so far been satisfactory. The improvement in the first case is evidenced by the facility with which the patient can turn round sharply, a feat particularly difficult to ataxics, even at an early stage of the disease. The other symptoms, subjective and objective, are also showing signs of gradual abatement. The case was one of unusual severity, the disease being of over six years' duration.—*London Medical Press*

**COCAINE-POISONING BY VESICAL INJECTION.** Dr. Alejandro Settler, of Madrid, has recorded a case of cocaine-poisoning which presents some peculiar features. A patient suffering from painful cystitis and chronic prostatitis had been in the habit of injecting twenty or thirty grams of a four-per-cent solution of cocaine into his bladder daily for seven months. When he came under the care of Dr. Settler, that gentleman determined to try the effect of injecting a solution of nitrate of silver into the bladder, previously made as far as possible insensitive by the injection of a four-per-cent solution of cocaine. On the second day of this treatment Dr. Settler injected the cocaine, leaving it in for twenty minutes and then drawing it off. The caustic solution was then injected and drawn off, and lastly the bladder was washed out with warm water. As the pain caused by the nitrate of silver was severe and persistent, the patient himself injected cocaine into his bladder—an art in which long practice had made him proficient—and drew it off in from fifteen to twenty minutes. Soon after the last injection symptoms of a somewhat alarming kind showed themselves. The patient, who was naturally of a very taciturn disposition, suddenly began to talk with the

greatest volubility. His sentences were unfinished, his speech indistinct, and his voice thick and quavering; he complained of giddiness and nausea; got up and sat down suddenly; and his gait was so unsteady that in walking he had to cling to the furniture. The tongue, mouth, and fauces were quite dry, the mucous membrane blanched, the body covered with cold sweat; the pulse was small and thready, beating 105 in the minute; he two or three times vomited glairy matter. Eight hours after the onset all these symptoms disappeared and the patient was quite well again. It should be mentioned that the course of recovery was twice interrupted by slight relapses, all the symptoms suddenly returning for a minute and a half. Dr. Settler thinks it remarkable that poisoning should have occurred in so thoroughly seasoned a subject; but it may be pointed out that a much larger dose than the patient was accustomed to was no doubt absorbed, four injections of the alkaloid having been made in one day.—*British Medical Journal.*

**FATAL CASES OF COCAINE-POISONING.**—Two fatal cases of cocaine-poisoning have recently been reported in Italy, one by Dr. Zambianchi, of Vigevano, and another by Dr. A. Montalti, of Florence. In the former, a lady suffering from recurrent cancer of the breast had four syringefuls and a half of a five-per-cent solution (equivalent to 225 milligrams) of cocaine injected hypodermically near the proposed site of operation. Immediately after she was seized with epileptiform convulsions, which lasted fifteen minutes. Artificial respiration was performed, and she rallied for a moment, but the convulsions came on again, and in five minutes more she died. The second case was that of a woman suffering from phthisis of one lung, to whom five grams of a thirty-per-cent watery solution of the alkaloid, equivalent to one gram and a half of the hydrochlorate, were given internally by mistake. Fifteen minutes afterward she began to wander in mind, complaining that a morsel of food had stuck in her throat, and making fruitless efforts to vomit; at the same time she became so cold that she had to be wrapped in hot blankets. The delirium increased, her face was pale, the pupils dilated, the lips cyanotic, and the pulse imperceptible. Unconsciousness supervened, and in a short time she died. Dr. Montalti was ordered by the Tribunale Correzionale, of Florence, to make a medico-lega examination. He found intense congestion of the brain and spinal cord, as well as of the membranes. The surface of the brain was covered with a thin layer of sanguinolent fluid

while the subarachnoid space was full of serum. Sections of the brain substance in various directions showed everywhere innumerable minute bleeding points, the drops being confluent so as to give the whole cut surface a reddish appearance. There were some recent hemorrhagic infarcts in the healthy lung; the heart was firmly contracted, both ventricles containing a little blood; the spleen, liver, stomach, and small intestine were excessively congested; the kidneys and the bladder were normal. Precisely similar conditions were found in rabbits in which poisonous doses of hydrochlorate of cocaine were injected hypodermically. Dr. Montalti says this is the first case of cocaine-poisoning in which the *post mortem* appearances have been described. In his opinion they show that the mechanism of the poison consists in vaso-motor paralysis, which causes an engorgement of the vascular system. *Ibid.*

**AMYLENE HYDRATE.**—Dr. Jumon (*La France Médicale*) recommends amylene hydrate in three-gram doses as a hypnotic. Its action is stronger than that of paraldehyde, but less so than that of chloral. It first produces a period of excitement, which is quickly followed by sleep. He employs the drug in diseases of the alimentary, circulatory, and nervous systems, and quotes the good results obtained from its use by Dr. Gurther, of Königsberg, and Dr. Dietz, of Leipzig. Amylene hydrate is soluble in eight parts of water. *Dublin Medical Journal*.

**THE USE OF ANTIPYRIN IN THE NASAL PASSAGES.**—F. Whitehill Hinkel, M. D., draws the following conclusions from the results obtained by the use of antipyrin upon the nasal passages (*New York Medical Journal*, October 20, 1888): (1) A solution of antipyrin possesses hemostatic properties when sprayed into the nose, though not superior to cocaine. (2) Antipyrin in about four-per-cent solution may be used upon the nasal mucous membrane with temporary relief to occlusion from engorgement of the turbinates, and with sedative effects upon irritable states. (3) It is most effective where the element of irritation exceeds that of inflammation. (4) It presents an advantage over cocaine in not producing local numbness and dryness, and, in the absence of the general stimulating properties of cocaine, causing sleeplessness, headache, etc. In cases such as hay fever, where an agent of relief is used for long periods, antipyrin as a nasal spray is less likely than cocaine to produce constitutional disturbance or to lead to a habit. (5) Antipyrin presents the disadvantage

of causing more or less severe smarting, and of being unequal to the relief of severe inflammation or extreme occlusion of the nares. (6) Its antiseptic and stimulant properties will probably make it serviceable as an application to fresh wounds and to granulations and ulcerations in the nasal chambers. (7) Combined with cocaine, it increases the local action of the latter, enabling it to be used in weaker solution.—*Therapeutic Gazette*.

**THE PREVENTION OF RABIES BY PASTEURIAN INOCULATION.**—The inoculations performed last year at the Odessa Bacteriological Station against bites from rabid animals show results no less satisfactory than those of the preceding year. The number of persons inoculated was 454; of these, 398 were bitten by rabid dogs, 38 by cats, 7 by wolves, 3 by a man suffering from hydrophobia, 1 by a rabid cow, and another by a wild boar. Six persons underwent inoculation simply as a preventive measure. The patients actually bitten by rabid animals may be divided into three classes. First, are the dangerously wounded, that is, persons bitten on the head, face, or arms; of these there were 89. Of the second class—the slightly wounded—there were 206; and in the third category, of those who had received bites through their clothing, there were 158. In only 44 out of the total 454 cases treated was the actual presence of rabies in the animals inflicting the bites not conclusively proved. Two patients died after the inoculatory course prescribed, but both of these cases belonged to the dangerously wounded class, one of these patients being dreadfully lacerated about the head by a rabid wolf. Altogether six patients died during and after the inoculations. Of seven persons bitten by the same rabid wolf, one succumbed. Of 44 persons bitten by other rabid animals, 5 died, giving a percentage of 1.1; of these, 4 were dangerous cases. In the 158 who were bitten through the clothes there was no fatal case. *British Medical Journal*.

**ADDISON'S DISEASE.**—Dr. Suckling (Midland Medical Society) read notes and showed specimens of a case of Addison's disease, without marked pigmentation, recognized during life. The patient, a man aged forty, had been ailing about nine months. His strength rapidly failed, and for the last three months of his life he was unable to work. He had suffered from attacks of vomiting and flatulence, and had complained of backache. Latterly he had had attacks of fainting and vertigo. Any sudden movement made him giddy. During the last six weeks of his life he had been

much worse, fainting even when he sat up in bed. When he was admitted into the Queen's Hospital he was unable to sit up in bed, and scarcely able to speak. He was thin, but not markedly emaciated; his complexion was dusky, but the pigmentation was insufficient to attract attention. A few dark-brown spots were present on the arms and fore-arms; the axillæ, mammary areolæ, and umbilicus were dark-colored. The mucous membrane of the mouth was not pigmented. The patient stated that he thought he had been getting darker in complexion during his illness, but his wife had not noticed any change. There was a little tenderness over the area of the suprarenal capsule on each side. The patient died suddenly a few days after admission. There was no family history of importance. The man had been a foreman in a factory, and for years was occupied for many hours daily in a dusty warehouse. At the necropsy caseous nodules were found at the apex of each lung. The heart weighed only eight ounces, and was very flabby. The liver weighed three pounds five and one half ounces, and was fatty. The suprarenal capsules were not much enlarged, but both were full of caseous tubercle. Dr. Suckling stated that the extreme exhaustion with syncopal attacks enabled him to make a decided diagnosis before death, while the vomiting and backache confirmed him in his opinion. *Ibid.*

**A READY AND EFFECTUAL METHOD OF APPLYING THE PRINCIPLES OF MANIPULATION IN THE REDUCTION OF RECENT DISLOCATIONS OF THE SHOULDER-JOINT.**—As a ready and simple method of reducing dislocations of the humerus, I can recommend the following maneuver, which I have successfully put in practice in three cases of recent luxation of the humerus (subcoracoid) coming under my personal care.

The patient—suppose the right humerus is dislocated—is placed on the floor on his left side, or the surgeon stoops and kneels beside him, and, taking the patient's right arm, places it with the fore-arm lying over the operator's neck, while the patient is directed to grasp the wrist of the injured arm with the left hand, or lock his fingers together. The surgeon is thus hugged by the arms of the patient. Now, in order to effect reduction, traction should be made "in the axis of the bone perpendicular to the glenoid fossa," as this allows relaxing of the muscles (the main obstacle to reduction), and is the best method of overcoming the mechanical difficulties preventing reduction. By gently raising himself into a

more erect position, the surgeon makes traction on the extremity in a gradual, continuous, steady pull, and the weight of the patient's body acts as the counter-extending force, while the right hand of the operator, placed on the axilla, feels the head of the bone, and with a gentle touch of his fingers the bone slips into its place. The hands of the operator are entirely free to guide the head of the bone, the right one in the axilla, the left one placed on the shaft of the humerus steadying it, and both helping the mind to change the direction of traction into the line of least resistance by the swaying motion the surgeon can impart to his body in the "hunkering" position in which he acts.

The principles are simple and easily understood. By humoring the muscles and their various degrees of tension, spasm, and resistance the bone can be easily restored to its natural relation with the scapula. No extraordinary effort on the part of the surgeon is required; all movements can be done, as they should, in the gentlest manner possible, persevered in slowly and steadily, without jerking; and it is found that by moderate extension, and without any assistant's help, the surgeon, with surprising ease, and in less than two minutes, feels the bone go into its place with a slight snap.—*Mr. George S. Thomson, Ibid.*

**THE TREATMENT OF CHRONIC ENDOMETRITIS.**—In this tedious and troublesome complaint the endometrium degenerates into a pyogenic membrane, and the uterine cavity becomes converted into a chronic abscess. Acting on this view, I have for some time past treated all cases in which I find the characteristic muco-purulent discharge, existing by rapid dilatation, cleansing of the uterine cavity by the curette, and the insertion *directly afterward* of one of my spiral wire stems, which, by keeping the cervical canal patulous, straightening the uterus, and permitting free drainage, I have found to yield excellent results. The stems I have last designed (made by Messrs. Arnold & Sons, London) I find can be worn without inconvenience by the patient without being confined to bed if the proper sized stem be chosen, as I have now added a flat disk of wire at the base of the stem which makes it self-retaining, and I have been much pleased by the relief afforded to some patients with whom every other means had been previously tried except the flexible stem.

The conclusion I have come to is, that

unless free exit is given for the secretions, the smallest quantity being allowed to remain *in utero* keeps up the unhealthy condition of the endometrium, just as a similar secretion allowed to remain long enough in the bladder will thwart all our efforts to keep that organ aseptic.

I find that a great number of the reflex symptoms complained of by patients suffering from chronic endometritis vanish for good, and all when the treatment I have described is adopted, and I hope that others with larger opportunities than I possess will give the stem a trial. There can be no difficulty in removing it even if worn for a considerable time, as traction on the lowest strand of wire will remove the whole with ease, as the wire of which the stem is composed is slight, and will unwind from below with the certainty of doing no damage to the cervical canal.

Greenhalgh's stems have the disadvantage of not being self-retaining, unless the patient is kept in the recumbent position, and also, being composed of rubber, get rapidly fetid, even in cases where the syringe was daily used. I have the greatest objection to rubber pessaries of all kinds, as they never keep clean, always have a bad odor when removed, and are not lasting, besides being, as a rule, expensive. I think my stems on trial will be found to supply a want, being light, cheap, lasting, and cleanly, and I venture to say an improvement on any other stem pessary I have seen.—*Mr. Alexander Duke, Ibid.*

**A NEW TREATMENT OF ANEURISM.**—Our Glasgow correspondent sent us last week a short account of a demonstration by Dr. Macewen of a new method of treating aneurisms. Needles are passed into the sac in such a way as just to touch the lining of the opposite wall. The oscillation of the needles causes a succession of fine scratches "on the inner surface of the endothelium, irritating it slightly and leading to the proliferation of leucocytes," which develop into a white fibrous mass. It is certainly difficult and probably unsafe to criticise a method of treatment without a knowledge of all the details, which were no doubt forthcoming at the meeting at which the demonstration was made. For example, we do not know if this method has been tried in the human subject, and whether the results have been submitted to careful examination. But, judging from the brief account quoted from, this method does not commend itself to us. We can not think that it is based on right principles.

Of course, we need not say that in aneurisms coming under a surgeon's notice there is no endothelial lining of the sac, and that in the majority of cases there is more or less blood clot or laminated fibrin. We can quite imagine that the scratching of the needles might be useful in starting fresh coagulation, and so leading to the consolidation of the aneurism. But it would require enormously strong evidence to prove that proliferating leucocytes could organize into a firm mass of connective tissue amid the tumultuous flow in a large aneurism. And it also seems clear that the layers of laminated fibrin within the true sac of an aneurism are a very serious obstacle to organization of any material within them. Other practical objections to this plan of treatment are the possibility of causing ulceration of the sac or acute inflammation of the surrounding tissues, and also the difficulty of adjusting the needles with sufficient precision.—*London Lancet.*

**THE COMBINATION OF ANTIPYRIN AND MORPHINE.**—Antipyrin powerfully relieves the pain of incurable cancer. I find it acts best when given with morphine, the analgesic effect of which is greatly enhanced. In malignant affections of the mouth and tongue, which commonly require such large doses of morphine, the relief given by the above combination is very marked. Antipyrin, with its congener antifebrin, forms an especially valuable addition to our resources in cases when, from coexisting renal disease, opiates are not tolerated by the patient.—*Dr. Herbert Snow, Brit. Med. Jour.*

**SALICYLIC ACID AS A DIURETIC.**—After a series of investigations on this subject, Huber concludes that salicylic acid is one of the safest and most important diuretics. The greatest increase in the amount of urine seems to occur in rheumatic fever and serious pleurisy, whether the temperature is raised or not. In all cases the total loss of water by the skin and urine was increased, and the solids of the urine were increased. In ordinary pleurisy and in four cases of cardiac dropsy the drug acted well.—*Lancet and Clinic.*

**TREATMENT OF SCABIES.**—Rub a third of this mixture into the whole surface of the body, from the neck downward, at bed time.

Flowers of sulphur.....	5i;
β-naphthol .....	5i;
Balsam of Peru.....	} aa ʒi. M.
Vaseline.....	

# The American Practitioner and News

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## CAPILLARY PULSATION AS A DIAGNOSTIC FEATURE IN HEART DISEASE.

The London Practitioner for March contains an original and ingenious paper on this subject by Walter S. Lazarus-Barlow, M. B., B. A.

Noting the diversity of opinion among writers as to the significance of capillary pulsation, and the difficulties attending its observation, the author sets himself to the solution of the problem in a systematic manner, and with results that seem to be of great practical worth. The substance of the paper lies in answers given to three questions, viz:

1. What is the capillary pulse?
2. How may it be accurately observed?
3. What diseases does the phenomenon accompany?

In answer to the first question the author says:

"The [arterial] impulse expends itself upon the capillaries, is lessened by friction against the walls of the arterioles, and, by a spread over a larger and larger area, becomes slower in its progress onward, while the elasticity of the arterial walls assists by converting the intermittent action of the heart into an even flow. Under certain conditions, as under those which affect a salivary gland when in a high

state of physiological activity, the pulse may extend into the veins, extending to them of course through the capillaries. This is referred to a vaso-dilator action on the afferent vessels, whereby their caliber is enlarged and friction is not applied to so great an extent, relatively, to the amount of blood passing through in a given time as in a quiescent state of the gland. Hence, in this case the intermittent heart beat is not entirely canceled, but a portion of it remains sufficient to cause a venous pulse."

In answer to the second question the author notes the fact that the salivary glands are too deeply seated to admit of observation in practice, while the capillaries of the skin are practically excluded from view by the thickness of the epidermis. Irritation of the skin over a small area, as practiced by some physicians, gives no trustworthy result, since the heightened physiological activity in the vessels thus produced is a disturbing factor which can not with certainty be eliminated.

The fundus oculi, the area of hyperemia surrounding a scab, spots of psoriasis or other hyperemic skin diseases, are generally so circumstanced as to be inaccessible by ordinary means, or they give unreliable indications.

The finger nails and the mucous membranes are, in his opinion, the only points available for observation. Of the first he says:

"The conditions required are fairly well represented, for the capillaries are near the surface, and they are seen fairly easily through the transparent keratin; while a little gentle pressure, by rendering part of the matrix exsanguine, brings the contrast out more clearly."

In practice the method of Quincke will give more satisfactory results: "Extend the fingers completely, when a whitish area appears under the nails. A red area, near the free margin of the nail, advances and returns with each pulse beat." (Landois and Stirling's Physiology, American edition, 1886.)

The mucous membranes, and of these the inner surface of the lip, afford the best site for observation of the phenomenon. "The flushing, however, is not so well seen if the lip be merely looked at, as if a portion of the blood be pressed out by placing a common micro-

scopic slide over the part." The area thus pressed upon will appear white for the most part, but some point in it will be seen over which the degree of pressure will be such as to afford the requisite conditions for observation. In practice it is essential to note that the advance and recession of the redness (which is the index of capillary pulsation) is synchronous with the arterial pulse of the patient.

In attempting to answer the third question the author made search for the capillary pulse in about one hundred subjects, mostly hospital patients, with and without cardiac disease, with the following result: Of cases of *morbis cordis* there were fifty-six, thus distributed:

"Double aortic disease, with capillary pulsation present, 33 (in eight of these a *post-mortem* examination completed the diagnosis); a systolic murmur at the second right costal interspace, with capillary pulsation present, 2; a systolic murmur at the second right costal interspace; with capillary pulsation absent, 4; mitral disease, with capillary pulsation absent, 14; pulmonary stenosis, with no capillary pulsation, 3. Of these the main lesion is in many cases alone regarded in placing them under headings, for often more than one lesion was present. A continuous series of cases of aortic-valve affection therefore shows itself, accompanied by a corresponding increase in frequency of observation of capillary pulsation."

"(1) Fifty cases of healthy hearts, with capillary pulsation entirely absent; (2) four cases of aortic systolic murmur, with no regurgitant murmur, and capillary pulsation entirely absent; (3) two cases of aortic systolic murmur, with no regurgitant murmur, and capillary pulsation present; (4) five cases of aortic systolic murmur, with very faint diastolic murmur audible with care, and capillary pulsation present; (5) twenty-eight cases of definite double aortic murmur, with capillary pulsation present. Classes 4 and 5 constitute the cases of aortic regurgitation, definitely diagnosed as such on auscultation.

"Viewing the cases from a different standpoint, forty-six cases showed capillary pulsation. Of these thirty-nine had some greater

or less degree of affection of the aortic semilunar valves, as estimated by the condition of the second sound; six cases showed capillary pulsation on one occasion, while subsequently it was absent, no cardiac lesion being at any time discovered. Over eighty-three per cent of the cases in which the pulsation was found therefore presented aortic valvular affection, while fourteen per cent of the remaining seventeen per cent can be explained on a rational hypothesis. According, then, as aortic regurgitation manifests itself to the ear by a murmur, so does capillary pulsation manifest itself by flushing."

It will be seen that in the foregoing we are indebted to the author for a ready and definite means of observing capillary pulsation, and for a powerful array of clinical testimony in favor of the theory that capillary pulsation is highly symptomatic if not pathognomonic of aortic insufficiency. A search for capillary pulsation should always be made in doubtful cases of cardiac disease, since its presence or absence seems likely to make clear many a dark diagnosis, and to settle the question of the exhibition or non-exhibition of digitalis in the case.

## Notes and Queries.

THE INFLUENCE OF CERTAIN MEDICINAL AGENTS UPON THE BACILLUS OF TUBERCLE IN MAN.—Although the inefficacy of treatment in almost all cases of tuberculosis (pulmonary and laryngeal), and its almost certain fatal issue in most instances are sad truths, still few of us care to confess to ourselves the fact of its incurability, and fewer are bold enough to record the apparent uselessness of all treatment.

Dr. G. Hunter Mackenzie, in the Edinburgh Medical Journal for January, 1889, has stared the truth full in the face. In the beginning he brings forward the fact that the number of tubercle bacilli found in the sputa of any case does not seem to bear any reference to the severity of the case. A case may go on for years with an enormous number of bacilli found at every examina-

tion. This seems very plausible. The fact that the bacilli seem to grow less at each examination may not indicate an improvement; for naturally, when the larynx is the seat of disease, the sputa must swarm with bacilli, while in a lung lesion alone the bacilli-laden secretions coming from a greater distance may pass in other directions as in other parts of the lung or in the stomach.

As the treatment is directed against this primary cause of the disease, the only way to influence the bacilli is by climate, by general or by local remedies. He has seen climate cause improvement for a time, but he has never yet witnessed the complete disappearance of tubercle bacilli follow on or be induced by climatic changes. Dry climate with the minimum variation of temperature is most favorable, a low temperature diminishing the amount of expectoration and the bacilli. The latter, however, seem almost always to be present, for even when the non-ulcerating tubercular laryngitis can not be distinguished from a simple chronic laryngitis, the presence of the bacilli, as many of us know by experience, will alone make the diagnosis.

It is not difficult to select a host of bacilli-destroyers, but an efficient antiseptic must be destructive to the bacillus and innocuous to the host. He has tried all possible antiseptics in spray in as strong a solution as feasible, and all in vain. Dry inhalations are objected to on account of their desiccating and irritating effect upon the laryngeal mucous membrane.

According to the experiments of MM. Filleau and Léon-Petit, the tubercle bacillus is one of the most refractory of all micro-organisms to the action of the most destructive agencies. It maintains its virulence after lying for forty days in putrid sputum, and for one hundred and eighty-six days away from contact with air. It can live at a temperature between 86° F. (30° C.) and 104° F. (40° C.) The bacilli may be destroyed, but the spores are so tenacious of life that the most violent means, such as prolonged boiling, steaming, etc., are alone capable of

rendering them inactive. *Corrosive sublimate itself is powerless to disinfect the sputum.* Tuberculosis may seem to be cured at times, but the spores are only lying latent. In view of these facts, skepticism as to the cure of pulmonary or laryngeal tuberculosis may be pardoned.—*Maryland Medical Journal.*

**THE LIMITATION AND TREATMENT OF DIPHTHERIA.**—The frequency and the large mortality of diphtheria at the present time make this disease a natural subject of comment at medical society meetings. No more important topic can engage the attention of the profession than this. As one of the speakers pointed out, diphtheria caused more deaths in Boston alone last year than yellow fever caused in the whole of Florida. Consumption, pneumonia, and diphtheria may be considered the three great scourges of New England to-day.

Smallpox, so long the king of epidemic terrors, has been deposed from that position by the practice of compulsory vaccination and of segregation of the sick. But the Jenner of diphtheria has not yet appeared.

The committee appointed to confer with the board of health regarding the possibility of limiting the spread of the disease made their report.

They point out one difficulty which can be overcome only when public opinion is so instructed and informed as to sustain the health board in enforcing not only the removal of the sick but their retention in hospital until the danger of contagion is passed. This means a special hospital under the authority of the health board (precisely as is the smallpox hospital), and in addition the provision of isolated quarters for "suspects" and for the parents of sick children.

One question which has been sometimes looked upon as a point merely for abstract discussion acquires great practical importance in this view, namely, the relation between croup and diphtheria. Many a case diagnosticated as simple croup, and not considered as contagious, has been followed by similar cases among neighboring children, and we feel that an important contribution to the limitation of

diphtheria is within the power of the medical profession if they will treat their cases of croup as having infectious potentialities.

Another difficulty in the way of the prevention of diphtheria lies in our ignorance of many of the conditions which cause its spread. Direct contagion is the one important factor that we can and should deal with, but the many outbreaks in which the first case can not be traced to an antecedent one, and the lack of any uniformity as to the conditions of drainage, water-supply, etc., in the most infected communities, often overturn all our theories as to the extension of the disease. This was well brought out by Dr. Folsom's remarks in the discussion. It is further illustrated by the relative prevalence of the disease in some of the wards of Boston. For instance, ward twenty-five (old Brighton), which has of late been the heaviest sufferer of any in the city, has no conditions which offer any satisfactory explanation of the fact.

As to the treatment of an actually developed case of diphtheria, medical science has little to congratulate itself upon. The long list of suggested remedies discredits the value of any of them. A specific remedy would seem to be a great desideratum, but the exceeding shortness of the list of true specific medicaments does not offer any immediate encouragement in this direction.—*Boston Med. and Surgical Journal*.

**MALE HYSTERIA.**—According to Dr. Oze-retskofski, of Moscow, says the *Lancet*, the existence of hysteria among Russian soldiers is by no means an exceptional occurrence. The affection presents the same diversities of form that it does among women. Frequently men suffering from this affection are put down as malingerers. Other cases are looked upon as instances of serious but somewhat obscure organic disease, the true nature of the case being nearly always overlooked, because it is not generally supposed that soldiers are liable to hysteria. So real, however, does Dr. Oze-retskofski consider the existence of this male hysteria, that, having had an opportunity of studying no less than thirty-eight cases in the Moscow Military Hospital, he is con-

vinced that hysteria ought to be recognized as one of the affections which entitle the subject of it to exemption from military service. *Ibid.*

**FALSTAFF'S DEATH-BED.**—In *Blackwood*, this month, appears an able article from the pen of Dr. Creighton on the correct reading of that much-disputed passage in *Dame Quickly* report of Falstaff's death, "His nose was as sharp as a pen, and 'a babbled of green fields," and which Dr. Creighton would have us read, "His nose was as sharp as a pen on a table of green frieze," and supports this emendation with considerable force and learning. According to Dr. Creighton, Shakespeare made Falstaff die of the sweating sickness: first, because in the epilogue to the second part of *Henry IV* he promises that he shall die of "a sweat;" secondly, because many of the symptoms of death, as noticed by Mrs. Quickly, correspond with those given by Caius in his "Boke of Counseil against the Sweat;" and lastly, because the skin in "the sweat" often assumed a pimply roughness, which at first would be of a turgid and red tinge, but as the cadaveric hue of death came on would become *chlorotic* or greenish; in fact, the colloquial name given to the sweating sickness later on, in Germany, was *der friesel*. The arguments in favor of the older reading are, briefly, that the sweating sickness did not make its appearance till more than seventy years later; that, had Shakespeare really intended to represent Falstaff as dying of that disorder, he would have said "the sweat" instead of "a sweat." Moreover, it is not natural to make Mrs. Quickly such a minute clinical observer; while the picture of the drawn features and the childish and innocent babblings of the old sinner's delirium is one of those powerful touches that the poet delighted to draw. Besides, there was no necessity to make Falstaff die of an acute disease when Shakespeare had already represented him as suffering under a complication of disorders, with symptoms so graphically described that we can readily diagnose his disease. The Chief-Justice, addressing Fal-

staff, says: "Have you not a moist eye, a dry hand, a yellow cheek, a white beard, a decreasing leg, an increasing belly?" etc.; the yellow cheek, the increasing swelling of the belly, with the shrunken limbs, telling of the onset of the jaundice, and the ascites which accompany the latter stage of cirrhosis of the liver. Nor are the presages of his death incompatible with this view: the burning heats succeeded by sensations of intense cold, the rambling delirium, and pinched features are characteristic of death by this disease. But whichever reading may ultimately be adopted by the critics—and the question is sure of securing ample discussion—we must feel indebted to Dr. Creighton for introducing the subject, and giving us an intellectual treat in the scholarly manner in which he has arranged his facts.—*London Lancet.*

ENTERIC FEVER AND COW DISEASE.—The occurrence of enteric fever in the human subject as the result of a disease in the cow, and transmitted through the agency of milk, has been asserted as an actual fact from South Africa, and even in this country much doubt has in some cases arisen as to whether a similar result has not been brought about. Dr. William F. Murray, health officer to the borough of Forfar, contributes the latest account of an outbreak bearing on this subject. He heard of enteric fever in a dairyman's family outside Forfar in April of last year, and precautions were taken to prevent any milk contamination through human agency. But, notwithstanding this, cases of enteric fever occurred in Forfar early in May, and it was ascertained that they were without exception limited to the customers of the dairy in question. On further inquiry, the dairyman admitted that three of his cows had been suffering from a disease having the meaningless name of "stiffness," and that this disease existed before the occurrence of enteric fever in his family. Dr. Murray states that he has long since been driven to hold the view that illness in the cow or some changed condition in the milk itself has been a cause of enteric fever in

man, and he considers the mere fact of cases occurring in the dairy itself affords rather a confirmation than a refutation of this theory. Indeed, he says that "the people coming into direct contact with the diseased cows, and using the milk, would most likely be first affected." As to the use of the milk, we do not quite see why there should be priority of attack among consumers of it at the dairy; and, having regard to the extreme importance of the subject, we should have been glad to have had a more detailed report of the occurrence, especially as regards dates of attack, both of those who came into contact with the cows without using the milk and of those who drank it. With our present experience as to milk as a vehicle of disease, we should have thought that if the cause was a cow malady the consumers of the milk both in and beyond the precincts of the dairy would have been simultaneously attacked.—*Ibid.*

KOCH ON ANTISEPTICISM IN WAR.—In the recent speech delivered at the Military School in Berlin, Dr. Koch has drawn attention to the measures to be employed against infectious diseases during war. It is true that the measures themselves are not new, but before the nature and biological characters of the infective agents were known the various means were employed in a hap-hazard manner, and in the one case a great many unnecessary precautions were used, while in the other the essential points were omitted. It is in showing us what are the essential and what the non-essential precautions in each case that the chief value as regards hygiene of the recent work on infective agents lies. With regard to the infective diseases, it is pointed out by Koch that overcrowding and bad hygienic conditions, however much they may predispose the patient for their reception, will not generate them; the infective agent must come from without. Hence it is of the first importance to recognize and isolate the first cases; in this way it is easy to prevent the spread of the disease, while, if it once obtains a foothold in a camp, it is very difficult to get rid of it. At the same time precautions must be taken to

prevent the infection of other individuals, based on the modes of entrance of the virus. Thus, some forms of virus enter by the respiratory passages, and the best method of combating them is free ventilation to sweep away the infective agents, and also to dilute them and thus reduce the chances of infection to a minimum. Others, again, such as cholera and typhoid fever, enter by the digestive tract, and here care must be taken with regard to articles of food and drink, with regard to infection from contact with soiled linen, etc., and with regard to pre-existing digestive disturbances. In some of these cases a change of locality is often of great service. Other infective agents only enter by wounds on the skin, etc., and here avoidance of contact is the chief safeguard. Dr. Koch's paper is worth reading, as indicating the various lines on which preventive treatment should be carried out.—*British Medical Journal*.

**THE MICROBES OF THE STOMACH.**—This was the subject of a recent communication to the Académie des Sciences, by M. Abelous. In the fluid obtained by frequent lavages of his own stomach (empty) he has isolated sixteen species of microbes, the morphological characters and action of which on alimentary substances he has studied. The sixteen species comprise seven known micro-organisms: the *sarcina ventriculi*, the *bacillus pyocyaneus*, the *bacterium lactis aërogenes*, the *bacillus subtilis*, *bacillus mycoides*, *bacillus amylobacter*, and the *vibrio rugula*. Of the nine species that have not been described, one was a coccus and eight were bacilli. All these microbes resist the action of artificial gastric juice for a time much exceeding the mean duration of stomach digestion, especially when the cultures were rich in spores. Each of these species of microbes has a more or less energetic action on certain alimentary substances: ten attack albumen, twelve fibrin, nine gluten, ten cause the more or less complete transformation of lactose into lactic acid, and thirteen form variable quantities of glucose from starch. But the most remarkable results, says Abelous, are seen in the action

of all these microbes at the same time on an alimentary substance, especially when some saliva is added to the substance. Very rapid and very energetic decomposition sets in, with the evolution of gas and the formation of such products as leucin, tyrosin, indol, skatol, certain fatty acids and ammoniacal compounds. It is a fair inference that these microbes are very important factors in the process of digestion. The real theater of their action, says Abelous, should be the intestine, not the stomach, since the duration of stomach digestion is not sufficient to allow the microbes to decompose appreciable quantities of alimentary material—if one may draw conclusions on this point from a study of artificial digestion.—*Journal American Medical Association*.

**THE MICROBE OF DIPHTHERIA.**—The announcement of the discovery of the microbe of diphtheria by MM. Roux and Yersin, of the Pasteur Laboratory, has led somewhat prematurely to sanguine hopes that the disease will now be amenable to prophylaxis by inoculation. The micro-organism of diphtheria, however, has been before now discovered by such investigators as Oertel, Klebs, and Loeffler. Nevertheless, but little fruit in the direction of successfully combating this highly fatal disease has yet accrued from these researches. We await with interest the full details of this latest inquiry, and shall be glad to see to what extent MM. Roux and Yersin have advanced beyond the stages reached by their predecessors in this field.—*Lancet*.

**FREQUENCY OF EXTRA-UTERINE PREGNANCY.** We have been informed that no less than four cases of ectopic gestation have been subjected to operation during the last eight days within the London postal district. One was operated upon at the time of rupture; in two we understand there was a twin fetus in the uterus. We are neither able nor willing to give details of these cases; any history so soon after operation would be imperfect and its publication objectionable. We note the remarkable fact as a sign of the times. When Parry's great

collection of the literature of the subject appeared in 1876, in the form of a small book, cautious surgeons and obstetricians doubted that so many cases could really be genuine. Since that date, however, attention has been turned to the subject, and men are better educated in pelvic and abdominal exploration. The history of ectopic gestation teaches how much more frequent a disease proves to be when it has long been recognized than it is believed to be when first discovered. Certain affections beyond the range of surgery are probably more common than generally supposed, for by surgery have ectopic pregnancy and other conditions amenable to operative treatment been brought to light when they otherwise might well have been overlooked.—*British Medical Journal*.

**COCAINE IN ANGINA PECTORIS.**—Professor Valerian G. Lashkevitch, of Kharkov, tried (*Novosti Terapii*, December, 1888, p. 440) hydrochlorate of cocaine internally, in the dose of one third of a grain, three or four times a day, in sixteen cases of angina pectoris associated with cardiac or vascular disease, or, as in some of the patients, angina apparently caused by excessive tobacco smoking. The results obtained justify the author in regarding cocaine as a genuine specific remedy for the affection. The attacks of angina were invariably relieved even on the second day of the treatment, and ceased altogether and permanently in the course of a few days. Recovery takes place still more rapidly when inhalations of oxygen gas are simultaneously employed.—*Medical and Surgical Reporter*.

**ANTIFIBRIN IN SCIATICA.**—In an obstinate case of sciatica in a man aged twenty-five, Dr. Austin Flint has recently tried large doses of antifibrin with success. It was determined to push the drug to the extreme limit of safety, and on the first day of treatment fifty grains were given within four hours. The patient became somewhat cyanotic, and half an ounce of whisky was given with the last dose. On the following day he was better, and that morning the patient took forty grains, in two

(equal) doses, at an interval of two hours; on the next, the third day of the treatment, the pain had completely disappeared; the patient walked without difficulty, and felt perfectly well. He was discharged on the sixth day, promising to come back if his pain returned. Two and a half months later he had not returned.

**GENERAL PARALYSIS IN THE FEMALE,** in relation to certain menstrual troubles, has been investigated by Dr. Gilbert Petit (*Thèse de Paris*, 1888), who concludes, from fifty-nine cases, that the development of general paralysis in women often causes menstrual troubles. These troubles are characterized sometimes by a sudden and definite arrest of the menstrual function, sometimes by marked irregularity of the menstrual periods. When there occurs a remission in the course of the general paralysis, the regularity of the menstrual function is re-established. The patients that have no menstrual trouble during the diffuse meningo-encephalitis appear to resist the disease better than those whose menstruation is completely arrested or made irregular.—*Journal Amer. Med. Association*.

**FALLACIES OF STATISTICS.**—The fallacious deductions which can be drawn from a consideration of statistics are well exemplified in some remarks recently published upon the influences of tobacco-smoking upon diphtheria. It was shown from statistics by the Vienna municipal authorities that in the last three years the number of women affected by diphtheria was three times greater than the number of male adults, and from these premises the rash conclusion was drawn that tobacco-smoking was to a considerable extent a prophylactic against diphtheria. The use of tobacco is not, however, the sole or most important difference. It is obvious that the mothers spend more time with their children, and that they are especially liable to infection during the watchful nursing of a sick child. It is also equally clear that, as a rule, the occupations of the female sex keep them more strictly confined to per-

haps unsanitary houses, while the males leave these ordinarily to work in factories or in the open air. The probable influence of these conditions must be reckoned with before credence can be given to the prophylactic action of tobacco based upon statistics rather than experiment.—*London Lancet*.

**WHIPPING AS A THERAPEUTIC AGENT.**—The *Savannah News* asks: Should a physician ever whip his patient? and answers the question by saying that the matter was brought up for decision at a Berlin police court some time ago. A doctor was asked to prescribe for a boy four years of age, who was suffering from slight ailment, but the child screamed so violently that it was impossible to examine him. After trying for a long time to soothe the child, the physician resorted to the old-fashioned method of giving him something to cry for, and boxed his ears. The child's mother not only resented this, but showed her resentment in a practical manner by summoning the doctor for assault, but the court decided that the medical man had acted for the patient's good, and so acquitted him.—*Boston Medical and Surgical Journal*.

**DEATHS OF EMINENT FOREIGN MEDICAL MEN.**—The deaths of the following foreign medical men are announced: Dr. Krakenburg, Professor of Comparative Physiology in Jena, suddenly, apparently by suicide (his manner had recently undergone a complete change, and it is thought that his mind must have given way); Dr. Chantrain, physician to the King of the Belgians, at the age of eighty-five; Dr. Don Valeriano Herrera, one of the physicians of the Spanish Royal Household; Professor Soyka, of Prague.

**DEATH IN SOOTHING SYRUP.**—Mr. D. Wightman, coroner for Sheffield, recently held an inquest on the body of an infant between four and five weeks old, who died from a dose of soothing syrup. The parents could neither of them read; so, not knowing the proper dose, they gave the infant half a teaspoonful of the medicine. It soon became

drowsy, and died in the course of a few hours. It appeared that the dose of opium it must have taken was about  $\frac{5}{32}$  grain. The coroner severely censured the chemist who had prescribed the medicine, saying that soothing syrup killed thousands of children and ruined the constitutions of thousands more; the latter, instead of growing up healthy men and women, were ill and delicate; and of the two, he thought these were more fortunate who were killed.—*Maryland Medical Journal*.

**THE INFLUENCE OF TOBACCO SMOKE ON MICROBES** was the subject of a note by Hajeck at the meeting of a Vienna medical society on January 17th. Basing his researches on the experiments of Tassinari, of Pisa, who showed that tobacco smoke hindered the development of microbes, Hajeck looked up the vital statistics of Vienna to see whether diphtheria is less prevalent among men who generally smoke than among women. He found that for the past four years the ratio of diphtheria cases in men to those in women was 1-2.8, or almost three times as many cases in women. This, he claims, bears out the experimental results of Tassinari. It may be suggested, however, that men, as a rule, lead more of an open-air life, and do not, so frequently as women, nurse children and others suffering from diphtheria. Israel showed that tobacco smoke destroys bacteria cultures. But it seems that Hajeck has based his conclusions on insufficient data. We should know the other habits of the males that had diphtheria, besides knowing whether or not they smoked.—*Journal American Medical Association*.

**SUBUNGUAL PULSE.**—Mario Sacchi describes, in *Riforma Medica*, 1888, No. 224, a second case of subungual venous capillary pulse. The first case was seen by Gioeco in a patient that had tricuspid insufficiency. Sacchi's patient was a woman sixty years of age, with relative tricuspid insufficiency, in which a systolic return current into the veins produced the venous capillary pulse. *Journal American Medical Association*.

**CANCER DIAGNOSIS.**—At a recent meeting of the Medical Society of the District of Columbia, Dr. J. F. Thompson said he had never seen a case in which he would rely upon the microscope for the detection of malignant cells in any fluid of the body. He was not alone in this opinion, as most surgeons consider that an absolute diagnosis is impossible. In malignant diseases of the bladder surgeons do not rely upon urinary analysis. It is impossible to make a correct diagnosis from decayed cells found in the fluids of the body. The same is true of the stomach and intestines when the fluids and cells are discharged. He had accepted such a diagnosis once, and that was not right. The recent European experience should teach us that it is impossible to diagnosticate with certainty a cancerous growth, even when it can be seen and felt by distinguished surgeons and pathologists.

Dr. Lincoln had not based his opinion of malignancy on the cancer cells as much as on the patient's general condition, with the tumor and cachexia. From the mobility of the growth he was inclined to agree with Dr. Thompson, but he was compelled to accept Dr. Schaeffer's report. The urine may not present cancer cells at all times.

**TOTAL DESTRUCTION OF THE SPINAL CORD** in mammals by means of a stream of cold water, which prevents hemorrhage, has been studied by M. Gley. This method enables one to observe the different vaso-motor actions, independently of all nervous influence of central origin. When the cord has been destroyed in this way, strophanthus causes a marked general vaso-constriction. By this method one may study the origin of the vaso-motor phenomena produced under the influence of certain medicamentous and toxic substances.—*Journal American Medical Association.*

**MEDICAL EDUCATION.**—At the annual meeting of the Board of Trustees of the Central College of Physicians and Surgeons of Indianapolis, held March 1, 1889, the following resolution, which had previously been

passed by the stockholders and faculty, received the unanimous vote of the members:

"That, after the session of 1890 and 1891, the Central College of Physicians and Surgeons require of each student who is a candidate for graduation evidence of four years' study of medicine and the attendance of three courses of lectures."—*Journal Amer. Medical Association.*

**CREOSOTE WITH COD-LIVER OIL AND SACCCHARIN.**—Dr. Seitz gives the following formula in the *Therap. Monatshefte*, 1889, No. 48:

Creosote.....	2.5 parts;
Cod-liver oil.....	200.0 parts;
Saccharin.....	0.1 part.

Dose: A tea to tablespoonful one to three times daily for adults; for children the amount of creasote should be less.—*Medical and Surgical Reporter.*

THE British Medical Journal, February 9th, publishes the conclusions arrived at by the physicians who made the autopsy on the late Crown Prince Rudolph, of Austria. There seems to be no doubt that he shot himself, and the conditions of his brain and skull justify the supposition that he was mentally deranged.

A CHAIR of Physical Examination for Life Insurance has been created in the University of Vermont, and Dr. Charles F. Stillman, of New York, has been elected as its first incumbent.

### SPECIAL NOTICE.

**THREATENED ABORTION.**—M. D. Makuna, M. R. C. S. Eng., Lic. Med. University, Bombay, 1874 Trebeebut, Rhondda Valley, South Wales, says: I have much pleasure in expressing my satisfaction with the results I have obtained by the use of Aletris Cordial. One of my patients, who had miscarried three times previously, took Aletris Cordial during the last three months of pregnancy and was delivered of a fine, healthy boy. I ordered it at her own solicitation, as she expressed so much ease and comfort after the use of the first bottle. I am now giving it to two more patients who have miscarried several times before, and I am in hopes of good results. I consider a valuable addition to the Pharmacopeia, on account of its antispasmodic and nerve-tonic properties, and I should not like to go without it.

# THE AMERICAN PRACTITIONER AND NEWS

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*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we retain downright facts at present more than any thing else.—RUSKIN.*

## Original Articles.

### GUNSHOT WOUND OF THE HIP: A CASE.\*

BY W. O. ROBERTS, M. D.

*Professor of the Principles and Practice of Surgery and Surgical Pathology, Medical Department University of Louisville.*

V. W., aged thirty-two years, a large muscular man, on January 11th, about 6 o'clock P. M., was shot in the hip while standing with his back toward his assailant, who was within ten paces of him. Immediately upon receipt of the wound the patient fell to the ground. With assistance he was soon able to rise and hobble into an adjoining house. Half an hour afterward he was placed in a carriage and driven to Dr. Yandell's office, where I saw him with Dr. Yandell. We found that the ball had entered the left hip two inches below the crest of the ilium and one inch to the left of the sacro-iliac articulation. There had not been much hemorrhage. The wound was sufficiently large to admit the end of the little finger. With a large probe it was found to be about three inches deep, while the ball could be detected imbedded in the ilium. During the probing the patient complained greatly of pain in the calf of the leg, and insisted that the ball must be situated there. The wound was now enlarged so as to admit with ease the index finger, and with it the edge of the ball could be felt protruding from the bone. Extraction of the missile was attempted by sizing the protruding portion with strong

forceps, but it broke off, and we then decided for the time to desist from further attempts at removal. The wound was thoroughly cleansed and dressed antiseptically. The hemorrhage during the operation was slight, venous in character, and came from the bottom of the wound. The patient was now conveyed to his home, two squares distant, in the carriage. Dr. Yandell was called to him at bed-time because of the pain complained of in the calf of the leg. This was relieved by morphia hypodermically. The following afternoon, Dr. Yandell being sick, I took charge of the case. There having been sufficient oozing of blood to soil the dressings, I removed them and found the mouth of the wound filled with a coagulum, but no fresh bleeding. I put on a new dressing, with a thick pad over the wound, without disturbing the clot. At midnight I was summoned in haste, and on reaching the patient found him almost pulseless from loss of blood. I was told that shortly before sending for me he had a vomiting spell, during which he felt something give way in the wound; that the dressing immediately became saturated with blood, while a considerable quantity passed through the dressings on to the bed.

Upon removing the dressing the wound was found filled with coagulum, but all oozing had ceased. I immediately removed the clots with my fingers, with the view of finding the source of the bleeding, but the hemorrhage had stopped completely. I then washed out the wound with a sublimate solution and packed it to the bottom with sublimate gauze; over this was applied a thick pad and the spica bandage. When the gauze was placed in the bottom of the wound the patient complained greatly of

\* Read before the Louisville Surgical Society, March 11, 1889. For discussion see page 231.

the pain in the calf of the leg. Morphine and atropia were given hypodermically and whisky by the mouth. I saw him again in five hours. There had been no further hemorrhage. Pulse more feeble and irregular; surface very pale. Patient had slept but little and was very restless; complained of great thirst and nausea. He had vomited several times. The pain in the calf of the leg, which was relieved for a while by the hypodermic, was now very severe. One two-hundredth of a grain of digitalin was given hypodermically with one fourth grain of morphia. Whisky was discontinued, and nothing allowed by the mouth but water and milk. Three hours afterward Dr. W. L. Rodman saw him with me. There had been no further vomiting; the patient had taken a glass of milk. The pulse was a shade better. We agreed to continue the digitalin every three hours, and to give the morphia when required for relief of pain. The dressing was not disturbed. At 6 o'clock that evening there was a decided improvement in all the symptoms. The pulse was now quite regular, but still very feeble. Patient had taken two glasses of milk. Nausea was slight, but he was greatly annoyed with hiccough. No change was made in the treatment.

At 9 A. M. the following day patient's condition was much improved. The digitalin was stopped and iced champagne ordered. The patient went along now steadily improving, and on January 23d I permitted him to get up. After setting up a few hours he walked to a grocery at the end of the square on which he lived. He said this gave him some pain, but not much. On the 24th, which was a very cold, disagreeable day, he made the trip again, and sat on a box in front of the store for some little time. Upon his return home he had some pain in the left iliac region. During the night this grew more severe and extended down the limb, especially along the inner side and into the loins. I saw him at 10 o'clock the next morning, January 25th, when he seemed in great pain; pulse, 120 and full; temperature, 102°. There was no change in the appearance of the limb, and

not any evidence of inflammation about the wound. At 2 P. M. Drs. Yandell and Rodman saw him, and found the foot and leg edematous. Any movement of the limb caused him much pain. They enveloped the entire limb in absorbent wool, and over this applied a roller bandage. At 5 P. M. he complained of the bandage as being too tight, and upon removing it I found the entire limb edematous, with no swelling in the immediate neighborhood of the wound.

January 28th, I discovered a circumscribed swelling just above Poupart's ligament the size of a duck-egg, which was exceedingly sensitive to the touch. The leg now became slightly flexed and the patient was unable to extend it. February 5th, the temperature, which had been ranging from 102° to 101°, fell to normal. Considerable purulent discharge passed through the wound. Pain subsided and the iliac swelling became much reduced. February 8th there was a very marked change for the better in all the symptoms. The wound was discharging freely. I now decided to attempt again the removal of the ball. Drs. Rodman, Pearce, and Evans assisted me in the operation. When the patient was thoroughly anesthized the original wound was enlarged with my index finger. I could feel the opening in the bone, but not the ball. With an elevator I broke off a piece of the bone to enlarge the opening sufficiently to admit my finger and then found the ball—a No. 38 conical—and a fragment of the inner plate of the bone lying loosely in a small abscess cavity. After removing the ball and fragments of bone the wound was thoroughly washed and a dressing applied. The strictest antiseptic precautions were observed. No untoward symptoms followed the operation. The patient was out of bed in two weeks, and since then has been attending to his business. The wound has healed to a very small fistulous tract, and I believe that will be closed in a short time.

In examining the literature of the subject, I find that these wounds are exceedingly tedious in healing, extending over a period in some cases of months and in others of years

Regarding the prognosis of gunshot wounds of the pelvis there is great diversity of opinion among recognized authorities. Baron Percy taught that fractures of the ilium were not dangerous. Stromeyer says "injuries of the pelvis must be considered as dangerous as injuries of the head." Demme holds to the same opinion. Guthrie says, "although frequently fatal, they are not usually so at the moment." Lochmeyer claims that "death is the most frequent result of shot-fractures of the pelvis." Och-wadt says, "according to our observations we must consider shot-wounds of the pelvis, with or without injury of the viscera, very dangerous." Herr Beck, "results various, but not so fatal as generally supposed." Neu-dörfer goes so far as to say that "shot-wounds of the pelvis without injury to the viscera are never fatal and not even dangerous, but as a rule heal slowly."

In 1,494 cases of shot-fractures of the pelvis, taken from the surgical report of our late civil war, there were 918 recoveries, 544 deaths, and 32 with result unknown. Of the 1,494 cases, 799 were of the ilium, with 595 recoveries, 194 deaths, and 10 with result unknown.

An analysis of 151 operations upon the ilium shows 82 instances of removal of bone, 13 of removal of ball with splinters of bone, 55 of extraction of balls, and 1 of extraction of a piece of cloth. Of the 82 operations for removal of bone, 8 were primary with 3 deaths; 2 were instances of formal trephining, 1 proving fatal and the other failing to effect a permanent cure; and 57, with 6 deaths, were secondary operations, consisting of removal of exfoliations or of large pieces of necrosed bone or of the application of the gouge or chisel to carious parts; and 15 were extraction of sequestra at unspecified dates. Of the 13 cases of removal of balls with bone splinters, 2 were primary, with 1 death; 10 secondary, with 1 death, and 1 case, with a favorable termination, was of uncertain date. Of the 55 ball extractions, 14, with 5 deaths, were primary operations; 32, with 6 deaths, were secondary, and 9, with 3 deaths, were of un-

determined date. In the aggregate there were 29 fatal cases, or a small percentage of 19.2; 24 primary operations, with 9 deaths; 102 secondary, with 14 deaths; 25 of undetermined date, with 6 deaths. (Surgeon-General's Report.)

In my case I should like to hear from the Fellows, especially as to the cause of the pain in the calf of the leg at the time the wound was received, and also the cause of the subsequent swelling of the leg.

LOUISVILLE.

### PSYCHICAL IMPOTENCE.\*

BY I. N. BLOOM, A. B., M. D.

By psychical impotence is to be understood a functional disturbance of cerebral or peripheral origin, by which the penis is prevented from becoming sufficiently erect for purposes of copulation. It is, in my experience, the most common of all forms of impotence, and its prognosis by far more favorable than of all other kinds.

It might be well, before proceeding with this discussion, to explain as far as possible the mechanism of penile erection. Ulltzman, in his superb monograph on *Potentia Generandi et Potentia Coeundi*, begins by quoting Köl liker and Kohlrausch, who claim that the organic muscular fibers of the cavernous tissue relax under the influence of the nervi erigentes; that this causes an enlargement of the meshes and enables it to receive a greater amount of blood, and in this manner the erection is brought about by the increased amount of blood in the corpora cavernosa. This, however, does not explain the persistence of the erection, since, if the blood could flow back through the veins, the erection would never be brought about. In order that this blood might not return through the circulation, the following phenomena take place: At the beginning, the muscular elements of the corpora cavernosa relax through the influence of the aforesaid nerves. At the same time the arterie helicine fill the mesh-work with blood. This blood is carried back by veins which empty in part

\*Read before the Louisville Clinical Society, March 13, 1889.

into the vena dorsalis, and in part into veins in the lower portion of the penis, from the interior of the corpora cavernosa (pudendal and prostatic plexuses). When these latter are full of blood, the dilatation exercises a compression upon the veins which prevents a return of the blood from the corpora cavernosa. In addition to this, the bulbo-cavernosus muscle, together with the transversus perinei and the ischio cavernosus, by their contractions, compress the penis against the symphyse, and assist in the prevention of the return of the blood by pressure, causing the penis to rise—that is, producing an erection. When relaxation of the corpora cavernosa takes place—that is, when these nervi erigentes are not in full action—be it before or after intercourse, sufficient blood can not penetrate into the spongy bodies to prevent the return of the blood through the veins, and the penis remains either semi-erect or not at all erect. If the contraction of the muscular apparatus mentioned is incomplete, the erection is necessarily also incomplete. Thus it will be seen that the mechanism of erection is controlled entirely by nervous influences, and this influence may arise from the brain, as may be shown by the effect of lascivious pictures or erotic thoughts; or peripheral irritation may also cause it, as the erection so common in the morning in consequence of a full bladder. Overdistension of the seminal vesicles is another cause of erection from peripheral irritation. The painful erections accompanying gonorrhea are but reflexes from the prostate. Goltz found, in his experiments upon dogs, when the lumbar portion of the spinal cord was separated by section from the rest of the cord and brain, erections took place far more readily and much more strongly as a result of peripheral irritation of the nerves. From which he concludes that there are inhibitory nerves which go from the brain, and which to a certain extent hinder the formation of erections. This conclusion is probably correct, and is of the utmost importance in the consideration of psychical impotence, as we shall see later on.

Mental preoccupation is the most common cause of psychical impotence; and by mental

preoccupation I mean that condition of the mind in which its full powers can not be devoted to the sexual act; or, to express it better, in which that condition of the mind can not be obtained in which all other emotions are absent, and the patient is oblivious to every thing except the mechanical motion of coition. That this is so, men about town—"rounders," if you will—will prove to you by telling you that they are able to prolong the sexual act almost at will by forcing themselves to think of something else while engaged in the act. In this way these inhibitory nerves are brought into play. The erection becomes less strong, to be strengthened again at will, by the expulsion of extraneous thought. But to many the time comes when extraneous thought can not be expelled, when, in other words, the mind is preoccupied at a time when erections are desired. These people are temporarily or permanently impotent, because of the overweening power of the inhibitory nerves, and because the lumbar reflex center fails sufficiently to respond to ordinary stimuli so as to overcome the central inhibitory influence. This is the atonic impotence of Gross, as I understand it.

Fear is the most common kind of preoccupation of the mind; and the story of the man who, about to be surprised in bed with another man's wife, and being urged by her to continue his labors in the field of Venus, replied that his penis and the hair on his head could not stand at the same time, is one which has its foundation based on physiological truth. In many patients this fear of success in coitus is brought about by the recollection of masturbation of many years ago, the evil effects of which exist only in the imagination. In others, again, the recollection of former gonorrheas, or an unbelief in their potency from whatever cause it may be, may cause it. This fear strengthens the inhibitory central nerves, and they find intercourse impossible. Often a single failure in a man previously potent, when this failure has been brought about by emotional accidents, has been sufficient to bring to him the conviction that he is for all time impotent, and after a second failure the conviction becomes strengthened.

A few months ago a gentleman in the city was unexpectedly granted an opportunity in a parlor by a young lady whom he had been pursuing for some time. Conscious of the danger, he nevertheless attempted to crown his happiness or his perfidy, and for the first time in his life found himself unable to get an erection. Disheartened, distressed, a short time afterward he again attempted intercourse, this time with a prostitute, "to see," as he expressed it, "if in reality the old thing had gone back on him." Of course he found it had.

I have heard Ulltzman say that, after the Austrian panic of 1873, a large number of men who found themselves ruined financially were rendered completely impotent.

That grief has rendered men impotent is a fact to which I can testify from a patient whom I had two years ago. This impotence was not caused by a lack of desire, but by actual disability. Every physician who has had much genito-urinary practice must have had patients come to him, many who have led an absolutely moral life, and are about to be married, who say they believed themselves to be impotent. They will tell you that formerly erections were uncomfortably frequent; that the sight, the touch of their inamorata was sufficient to produce a feeling almost amounting to priapism. But that, now that the day of marriage had been fixed, erections were conspicuous by their absence. In most cases marriage cures these men of their terrors, but in some it persists a long time after marriage, and is one of the most difficult forms of psychical impotence to cure. Cases are reported where from one to two years after marriage the wives remained *virgines intactæ*, and only after proper treatment were they deflowered and impregnated.

Dislike or disgust are phenomenal factors in the production of impotence, and need only be mentioned here to recall cases to your mind. One gentleman in this city, a college-bred man, confessed to me, apropos of nothing, that he was impotent as far as his wife was concerned, but potent toward other women. Becoming interested, and feeling my ground carefully, I asked him whether it arose from dislike toward his wife. He denied this indignantly, and stated that it had come on gradually, but

confessed that it arose in large part from an utter indifference on the part of his wife to sexual intercourse. When asked as to whether he was able to have intercourse with her if he desired, he stated that he believed he could not.

Ulltzman refers to a class of patients who, previously potent, have become completely impotent after gonorrhea, without any discoverable organic cause. He thinks in these cases the disease has had a paralyzing effect upon the nervous apparatus of the prostate, and that the normal prostatic reflexes were interrupted and prevented in some way, and impotence resulted. I have had no experience with this class of patients.

Another class of men, of whom I have had one patient, are those whose minds are so thoroughly engaged with business affairs, on whose shoulders rest such grave responsibility, that for months and years carnal desires have found no place in their thoughts. When leisure comes at last, and their thoughts revert to the sexual act, they find themselves impotent.

LOUISVILLE.

## Societies.

### LOUISVILLE SURGICAL SOCIETY.

Stated Meeting, March 11, 1889, D. W. Yandell, M. D., President, in the chair.

Dr. W. O. Roberts reported the following case: On Saturday last I did an epicystotomy in a man who is forty years of age, and who has had syphilis for a number of years. For the last two years he has suffered at times from hemorrhage of the bladder. This hemorrhage would come on him at variable periods, sometimes every three weeks, or a month, and sometimes at longer intervals. He would lose a great deal of blood and become quite anemic. When he appeared at the University Clinic he was much emaciated, pale, and waxy in color. I sent him out to Sts. Mary and Elizabeth Hospital. He was put on tincture ferri chloride, given freely; and a few days ago, having been in the hospital two weeks, I put him under chloroform and examined him for stone. No stone was

found. There was no stricture, a No. 34 sound passing without difficulty. I concluded to open the bladder and see what was the condition of things there. This I did by introducing a grooved staff with a long curve, and, by depressing the handle, throwing the anterior wall of the bladder up against the abdomen. I think by this means the bladder can be opened without difficulty and without danger of wounding the peritoneum.

I made an incision through the abdominal wall two inches long, and could, by depressing the handle of the staff, throw the bladder up into the opening. This done, I made an incision through the walls of the bladder. This was made sufficiently large to enable me to introduce my finger without difficulty; and after doing so I discovered the base of the bladder, near the neck, covered with villous growths. These I scraped away with a spoon which I use for this purpose. The surface bled freely at the time. I scraped it until every particle of the new growth seemed to be removed. Then I sewed the wound in the bladder to the wound in the abdominal walls. After doing this I introduced a catheter into the bladder through the urethra, and with a fountain syringe let a hot solution of boric acid pass through the catheter into the bladder, and flow out through the wound in the anterior wall. I continued this until all hemorrhage stopped, which was in about twenty minutes. I then put an absorbent pad over the wound. The man was put to bed, and has since got on uninterruptedly well. He has had no elevation of temperature or hemorrhage.

Dr. D. W. Yandell: A lady, thirty years of age, married; borne four children; had in the abdomen a tumor which she states had been growing for ten or twelve years. She did not notice it, however, until a few years ago. The thing that led her to believe she had a tumor was an almost constant desire to make water. I think the subsequent history of the case will prove that she was correct in that the tumor began a long while before she could detect it by her hand.

The tumor was enormous, partly fluid and partly semi-fluid, and evidently composed of multiple cysts with thin walls. The diagnosis was apparently easy in all respects.

On opening the abdominal cavity there was an enormous gush of ascitic fluid, and then there welled out, right through the wound, a perfectly transparent cyst filled with a fluid that was clear as spring-water. I found that in opening the abdomen I had divided a portion of the cyst walls, which were exceedingly thin. Soon other and smaller cysts came into view, many of them filled with this transparent fluid, one only containing a straw-colored fluid. Others contained a semi-fluid resembling very thin calf's-foot jelly. Others again were distinctly of quite thick colloid.

I at once proceeded to break up these and pull them out as rapidly as possible, yet scarcely realizing what the work was before me. I am now sure I ruptured and saw several hundred cysts. The membrane, I think, was attached to every thing in the abdominal cavity—to the liver, spleen, omentum, intestines, bladder, ovaries, uterus—and filled the whole pelvic cavity from the anus upward. The cysts varied in size from a double fist to small pease. The appendix vermiformis was so invested by the membrane that it had to be peeled off before the organ could be released. The bladder was in the same way. I found it was out of the question to remove the entire sac, and after I had finished tying the pedicle, which grew from the left ovary, I discovered the rectum was surrounded by these cysts so that they filled up the entire pelvic space. I took out from around the rectum from seventy-fifty to one hundred of the smaller cysts.

The operation was done in an hour and ten minutes. Under hypodermics of whisky the patient rallied, and in the course of two hours her pulse became almost normal; she was completely out of shock. She expressed a desire to make water as soon as the operation was over. She slept well the night following, but vomited twice before morning. The following day, at 7 o'clock

A.M., her pulse was 114; temperature, normal. I was called away later and did not see her again. Dr. Roberts saw her about 9; she had vomited again; she then began to sink, and the next morning she died at 7:30.

I take the tumor to be a collection of hydatid cysts, apparently starting from the ovary, though I could not be certain about this. There was a pretty distinct pedicle, but the cyst walls were so thin that one could scarcely call it an ovarian cyst.

Dr. Mathews: Do you put much stress upon the temperature of the room in doing abdominal section?

Dr. Yandell: Yes, a good deal. I like to have the mercury at about 80°, or at least 70°.

Dr. Roberts: A young woman, twenty-one years of age, up to a year ago had menstruated normally, and had considered herself to be in perfect health. Eight months ago she began to have an uneasy sensation in her right side; she paid little attention to this, rubbing it now and then when it gave her discomfort. She did not detect any growth. Last December she had a violent pain in the implicated region. A physician was called in, and he discovered a tumor in the right iliac fossa at that time, not much larger than a hen's egg. The patient was then near her menstrual period. She has not menstruated since, and the growth has given her more or less pain. Six months ago she became very much jaundiced, and she is now as yellow as a person could be. She has been confined to bed since the 28th of December, this tumor being painful nearly all the time. Sometimes the pain shoots across the abdomen, the wall of which becomes very sensitive. The tumor is now very hard, it extends from the crest of the ilium to the margins of the ribs, and about half way over toward the median line. She is slightly tympanitic, and by deep pressure on the left side it struck me I could feel a number of enlargements about the size of guinea eggs. Her urine is very dark; she passes two quarts per day; bowels are constipated most of the time, for the relief of which she has to take a purgative.

She suffers more or less all day long, but especially in the evening and at night.

I take it this is a malignant growth, but as to the organ involved I am in doubt. The tumor seems not to extend quite as far up as the liver, and is not in the locality for a distended gall-bladder; yet, in view of the jaundice, I think the liver must be in some way implicated. The growth is too solid to contain fluid.

Under these circumstances would the surgeon be justified in opening the cavity?

Dr. Yandell: What good would you expect to do by opening the cavity?

Dr. Roberts: If we should find no enlargement of the lymphatic glands, but a diseased ovary only, this might be removed.

Dr. W. L. Rodman: Was there any history of gall-stone?

Dr. Roberts: No.

Dr. Rodman: Dr. S. W. Gross does laparotomy in all such cases, if just to make diagnosis, and reports that he has never had a death when it was done for this purpose.

The essay of the evening was read by Dr. W. O. Roberts. Subject, Gunshot Wound of the Hip. (See page 225.)

#### DISCUSSION.

Dr. W. L. Rodman: The case presents many interesting features. In regard to the questions asked as to the probable cause of the pain, I think that this could only be accounted for by pressure of blood and pus upon the great sciatic nerve. This is the only nerve the involvement of which can explain the symptoms in the calf of the leg.

The swelling of the leg, I think, is not to be accounted for by thrombosis. I think it was at first due to inflammatory products, and afterward to the abscess. The patient made too good a recovery for the trouble to have been caused by thrombosis. There was a complete subsidence of all this swelling after the pus was evacuated.

The effect of digitalin in this case is worthy of note. It would seem to demonstrate that to give the active principle hypodermically is preferable to any preparation of the drug given by the mouth.

Dr. Yandell: Would not the sudden occurrence of the pain be explained by the pressure of the inner plate of the bone upon the filaments of the sciatic nerve? The pain followed immediately upon the shot. The very moment the patient was shot he felt the pain in the leg, and said he was shot there. Now, that was too soon almost for hemorrhage to have caused it, and do you not think that the inner plate of the bone, being driven in by the ball, pressed upon the sciatic nerve (or its strands in the sacral plexus) sufficiently to cause this symptom?

Dr. Rodman: I do not think that thin spiculæ of bone could exert enough pressure upon the nerve through two thick muscles. If not due to the blood, is it not more directly due to the jarring of the nerve?

Dr. Yandell: I still incline to think that the suddenness with which the pain came on was due to the inner plate of the bone having been forced down on the nerve filaments. So distinctly did the patient feel the pain in the leg that he was positive the ball was lodged there, and actually pointed out the spot where he said it must be. And this pain he felt the *instant* that he heard the report of the pistol.

E. R. PALMER, M.D.,

*Secretary.*

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## Reviews and Bibliography.

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**Transactions of the American Ophthalmological Society.** Twenty-fourth Annual Meeting, New London, Conn., 1888. Published by the Society.

The meetings of this Society, composed of many of the most prominent specialists in this country, are always of interest, and the Transactions contain papers which are of scientific value. The volume before us contains as much interesting material as any previous one. Two cases of exophthalmos are reported. One by Dr. Buller, of Montreal, in which there was marked pulsation. This condition is rare, and in the case reported was probably due to a rupture of the internal carotid artery in the cavernous sinus, from a fall off a railway bridge.

There was a distinct bruit on auscultation. The common carotid was tied, and relief followed. Dr. Kipp, of Newark, reports a case in which there was double exophthalmos and a distinct bruit. Under intermittent digital compression of the carotid and the administration of iodide of potassium the bruit disappeared and the eye returned almost to the normal position. Dr. C. S. Bull gives the results of the surgical treatment in fifteen cases of membranous opacities in the vitreous. In fourteen decided improvement of vision was noted. In no case was there loss of vision from the operation. Therefore he concludes that it is a justifiable operation. This is a most interesting subject, since every ophthalmologist meets with cases in which there is a dense membrane stretched across the vitreous, interfering very much with useful sight. Some of these, we all know, are subject to improvement from treatment, such as those from certain inflammatory conditions in the choroid or hemorrhage into the vitreous. Others seem to resist all treatment, and not only interfere with useful sight but produce secondary diseases in the retina and complete blindness. A paper of much interest to specialists is the one by Dr. S. M. Burnett on an Analysis of the Refraction of Five Hundred and Seventy-six Healthy Human Corneæ, examined with the Ophthalmometer of Javal & Schiötz. An interesting paper, by Dr. W. F. Muendorf, on Symptomatic Myopia will well repay reading. Myopia, appearing as a symptom of a diseased condition in the eye, has not received much attention. As near-sightedness occurs in practice it is considered to be due either to elongation of the eyeball or increase in the refractive power of the lenticular system. Symptomatic myopia occurring as a result of a diseased condition may be due to traumatism, as dislocation of the lens forward, choroiditis, glaucoma, and iritis. The most persisting, however, is that due to swelling of the lens in the early stages of the development of cataract. Every specialist in eye diseases sees these cases. The reviewer recently op-

erated for cataract successfully on a man who at one time used convex glasses for reading. For the past three years he has been able to read without glasses, and when the operation was done he was using for the other eye — 4 D for distance, which gave sight equal to  $\frac{20}{100}$ . Cases of this kind are those who have so-called "second sight." They are therefore easily explained as a swelling of the lens and a myopia from development of cataract.

Dr. W. O. Moore reports three cases of hysterical blindness in the male. A paper, by Dr. David Webster, on Some Tenotomies for the Correction of Heterophoria, with results, is one of the interesting features of the volume. The teaching of Dr. Stevens, that most of the ills to which mankind is subject may be relieved by tenotomies of the recti muscles, has been extensively circulated. Dr. Webster, a most thorough, painstaking, and conscientious surgeon, gives the result of forty cases in which he followed the teachings of Dr. Stevens, after learning the method of operating from his own hands. Of the forty-one patients operated on, twenty-five were operated on once, sixteen were operated on twice, or fifty-seven operations in all. Three of the operations were on inferior rectus; seven, superior rectus; nineteen, external rectus; twenty-six, internal rectus. The cases operated on presented such diseases as epilepsy, chorea, hysteria, facial spasms, insanity, headaches, asthenopia. From a study of them Dr. Webster comes to the following conclusions: (1) No person should have a tenotomy performed simply and solely because he is the subject of heterophoria; that is, unless some annoying symptom, local or general, is present that may be due to want of harmony in the action of his ocular muscles. There must be a reason for the operation in addition to the existence of the condition to be corrected. (2) Very slight degrees of heterophoria may and should be corrected where troublesome symptoms exist which may be due to the too great use of the nervous force in coordinating the eyes. (3) It is true that all

other means that afford any prospect of relief should be tried before resorting to a tenotomy, although no time should be lost by unnecessary dilatory treatment. (4) Tenotomies for the correction of heterophoria should always be performed under cocaine, so that the effect of the operation may be accurately measured and properly limited. (5) In judiciously selected cases, where the operation is properly performed, the average results will be quite as satisfactory as the results of most other surgical operations.

In the discussion that followed this paper we get the opinion of such men as Derby, Mayo, Theobald, and others. They are all agreed that while many cases of ocular insufficiency are cured by the proper tenotomy of the ocular muscles, the indiscriminate cutting of these muscles for all kinds of ailments tends to bring the operation into disrepute.

J. M. RAY.

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**Wood's Medical and Surgical Monographs**, consisting of Original Treatises and of Complete Reproductions, in English, of Books and Monographs selected from the latest literature of foreign countries. With several illustrations. Published monthly. Pages, 259. Price, \$10.00 a year; single copies, \$1.00. New York: William Wood & Co. 1889.

This is the first number of the first volume of Wood's Medical and Surgical Monographs. The book made up of a series of six lectures, by Jonathan Hutchinson, F. R. S., on the Pedigree of Disease; a series of eight lectures, by Robert M. Simon, M. D., on Common Diseases of the Skin, and a third series of fourteen lectures, on The Varieties and Treatment of Bronchitis, by Dr. Ferrand. In the next volume we are promised Gonorrheal Infection in Women, by Dr. William J. Sinclair; On Giddiness, by Dr. Thomas Grainger Stewart, and a Critical Study of the Clinical value of Albuminuria in Bright's Disease, by Dr. Pierre Icaanton, of Paris.

The articles making up the present number are all of great value, and form a worthy continuation of the excellent medical library William Wood & Co. have for a number of years

supplied the medical profession of America on the most favorable terms, and by which they have been placed under lasting obligations. With medical literature of the best quality and at such cost, no medical man can find excuse for not being fully up with the times in his reading.

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**Case of Emperor Frederick III.** Full Official Reports by the German Physicians, and by Sir Morell Mackenzie. The Reports of the German Physicians, translated by HENRY SCHWIEG, M. D. Pages, 276. New York: Edgar S. Werner. 1888.

Sufficient time has elapsed since the death of the Emperor Frederick III to enable the reader to take an impartial view of the bitter controversy between his German and Austrian medical attendants on the one hand and Sir Morell Mackenzie on the other.

It is fair to say, that notwithstanding the bitter recriminations in which the respective parties indulge, and the pitiful exhibitions of temper on either side, the reading world is not all prepared to adopt the estimate of either side that is given by the other.

In Germany and England alike, the participants stand at the head of the profession. All occupy positions of social eminence. Some of them are trusted officials and even distinguished authors. The unworthy of the profession were not chosen for the high trust of aiding the idolized Emperor in his struggle with death.

The causes, then, of the controversy, and especially of its bitterness, must be sought deeper than in mere personal jealousy. It is part of a great chapter in race and national history as well. Reading between the lines, we find, first, the German physicians piqued at the thought that a diagnosis reached by what they for themselves regard as the ablest medical talent on the globe had been cavalierly set aside and their course of treatment rejected. In this there was national prejudice. But, further than this, they evidently concluded that Mackenzie had a friend at court in the person of the English-born Empress, whose influence he was able to cast in the scale against them; and it must be admitted that there are many things even

in the statement of Mackenzie which to an eye only a little biased might easily take such a cast. This feeling borrowed strength from the national antipathy of the Germans toward interference by women in men's affairs. Possibly, too, some light has been thrown on the subject by the revelations connected with the publication of the Emperor's Diary. While Mackenzie was supposed to be close in the confidence of the Queen, it is not to be supposed that some of the complaints so freely set forth in the German official report did not find a willing listener in Count Herbert Bismarck, and even in the great Chancellor himself. No doubt all the participants forgot at times the pose that in all cases makes up so much of greatness, and behaved in a way they would gladly revise; but the great medical scandal is to be set down to national and race prejudice and inherent human weakness rather than to the gross unworthiness of any of the trusted participants. The one thing on the part of Mackenzie that is hardest to excuse is the obtaining and exhibiting of a letter from the Emperor condemning the conduct of von Bergmann, and not brought forth till after the Emperor's death. If Mackenzie was blessed with the superior bearing (or court influence) that was the Emperor's confidence, he should also have maintained a magnanimity of refusing to take so great an advantage of his antagonist.

The controversy is at all events very readable, and, as many times as one may resolve to read something more profitable, if the book is in reach he will return to it till it is finished.

D. T. S.

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**A Manual for Hospital Nurses and Others engaged in attending on the Sick.** By EDWARD J. DOMVILLE, London, M. R. C. S. (England). Sixth edition. Pages, 100. Philadelphia: P. Blakiston, Son & Co. 1888.

This is our ideal of what a nurse's manual should be. Instead of making the subject a pretext for inflicting on the public a tedious treatise on medicine, as is the case with too many works of the name, the author tells in a concise and lucid style just the thing a nurse should know. It is worthy of unreserved commendation.

D. T. S.

## Abstracts and Selections.

CASES ILLUSTRATING THE TREATMENT OF UTERINE AND PERI-UTERINE DISEASE BY APOSTOLI'S METHOD.—The electrical treatment of uterine and peri-uterine disease has within the last year been the subject of considerable discussion and criticism. As a contribution to the literature of the subject the following notes should be of some value, especially as considerable time has elapsed since the cessation of the treatment, and there has been no relapse, the patients in Cases I and III remaining quite well, and Case II in the same state as when treatment was discontinued. In a recent report on the subject of the electrical treatment of uterine fibroids, Apostoli states that he has employed it in 278 cases of fibroma, or uterine hypertrophy, necessitating altogether 4,246 applications of the constant current, and that in 95 per cent benefit had been acknowledged. The mortality from the treatment is practically *nil*. There are two methods of utilizing electricity in the treatment of uterine diseases. In the first, two electrodes are inserted into the tumor, and the direct electrolytic effect produced; in the second, the intensity of the current is localized within the uterus, with the view of acting on the lining membrane of the uterus and indirectly modifying the nutrition of the tumor. The positive pole is placed in the uterus when hemorrhage or profuse discharge are accompaniments of the fibroid, because the negative tends to increase the bleeding. High intensities, 200 milliampères or more, are used, and this strength made possible by the employment of large electrodes of pliable metal, sponge, or (as Dr. McClure used) potter's clay, over the abdomen. Many chronic inflammatory conditions of the uterus yield readily to this treatment.

I. Mrs. M., aged thirty-five years; married eight years; no children. The patient was the subject of a bleeding myoma; uterus fixed; sound passing four inches. The hemorrhage, pain, and almost constant nausea and sickness had persisted for a month under ordinary methods of treatment. The woman was blanched and seemed at death's door. On April 25, 1888, she was admitted into the hospital, and a galvanic current of 60 milliampères was passed for seven minutes; the positive (platinum) electrode in the uterus and a large clay electrode attached to the negative were almost covering the abdomen. After the first application the sickness and nausea quite ceased, and

there was some diminution of the hemorrhage and pain. The application was repeated two days after with a current strength of 100 milliampères, resulting in a further diminution of hemorrhage and pain, with marked improvement in the appetite and the general condition. A third application of 112 milliampères was made four days after, with a further reduction of the hemorrhage. As this was now no longer an urgent symptom, the resolvent action of the negative pole (intra-uterine) to act directly on the mass, and thereby produce absorption, seemed more indicated. Six applications were made at intervals of four days, for ten minutes, with a current strength of 120 milliampères. The uterine discharge was now much lighter in color, and all pressure symptoms most markedly diminished, the bowels acting naturally without pain; sleep and appetite good. The patient had been getting about for the previous fortnight, and had regained a fair measure of strength. As there was still some oozing from the uterus, a return was made to the positive intra-uterine application. After six such applications had been made, at intervals of about a week, the patient expressed herself as being quite well—better than she had been for some years. The uterus was now freely movable and much diminished in size. There had been a normal period, with very little pain, lasting five days. Since then (June 10th) she has remained quite well.

II. J. G., aged thirty-five years, single, was the subject of parametritis of two years' standing, involving uterus and appendages. She had the look of extreme suffering, and said she was never free from pain, the attempt to raise her foot from the ground causing evidently much suffering; in walking, her feet were slid along the ground, her steps being very short. Two large nodulated masses could be felt externally, reaching well out of the pelvis. The uterus was firmly fixed, presenting a hard, irregular mass in the vagina; the os could with difficulty be made out. The sound passed three inches and a half. Before resorting to the galvanic current in this case, faradism with Apostoli's fine coil and bipolar uterine electrode was used for the relief of the pain for five minutes with entire success, the relief lasting four or five hours. Three of these applications were made daily. On May 23d the galvanic current was applied as in the previous case for five minutes, the negative pole being made intra uterine. Only 30 milliampères could be borne. These appli-

cations were made twice a week, and after the third she was decidedly freer from pain and tenderness. In all, six applications were made with the negative intra-uterine pole. The patient was able to walk about without pain, but there did not seem much sensible diminution of the tumor. By this time from 80 to 100 milliamperes could be borne. A negative puncture was now made into the most prominent part of the mass in the vagina on the left side, where it seemed softer; the trocar, insulated to quarter of an inch, and a current of 60 milliamperes passed for three minutes; this caused considerable pain. Two more punctures were made at an interval of a week. After the last there was very considerable pain, persisting for a day. A plug of iodoform gauze was inserted after each puncture and renewed the second day. There was each time some slight purulent discharge, and a distinct slough separated about the sixth day. The condition of matters within the vagina had considerably improved. The cervix was now well defined, and the fullness, especially on the left side, very materially less. The positive intra-uterine electrode was used after this four times, at intervals of four or five days, with a current strength of 80 milliamperes. The tumor, as seen externally, was smaller and less prominent from the vagina. The uterus was movable to a slight extent, and there was a well-defined fossa on each side of the cervix. The patient was discharged on October 11th, on the whole very much better, and was very anxious to come back again for further treatment.

III. Miss K., aged twenty-five, unmarried, was admitted on April 10th. This was a severe case of hysteria, ovarian pain, and tenderness, with amenorrhea of six months' duration, most obstinate constipation, and a peculiar attack of faintness and dyspnea, with sudden and great distension of the abdomen. Her mother stated that she had at one time absolutely eaten nothing for a fortnight, and that she had been ill over a year. She was well nourished, and had an excitable, nervous look. She complained of severe pain in both ovarian regions, and there seemed much tenderness. Faradism by the bipolar vaginal electrode was applied, and before the current had passed for five minutes she expressed herself as being free from pain, and deep pressure could be borne in both ovarian regions. The faradism was repeated eight times; besides, she had five applications of static electricity. At one time during her stay she had an almost typi-

cal attack of hystero-epilepsy. After a two months' residence in the hospital, she was discharged quite well, the catamenia having come on in the meantime. I have recently heard from her mother that she continues quite free from all pain and hysterical symptoms.

Remarks by Dr. McClure: In the first case the only other alternative in regard to treatment would have been removal of the appendages, or hysterectomy. I believe in electricity we possess quite as certain a means of controlling hemorrhage, and in this case, if not of absolutely curing the patient, at least of getting rid of all troublesome symptoms. In the second case the patient was not a good subject, having had hemoptysis, and the apex of one lung not being free from suspicion of disease; yet she was much benefited. The last patient presented the most severe manifestation of hysteria and ovarian neuralgia, lasting over a year, and uninfluenced by ordinary treatment. Apostoli's methods, as I have seen them carried out in Paris, were strictly adhered to. The antiseptic douche was used both before and after each application.—*Dr. McClure, London Lancet.*

AFFINITIES AND ANTAGONISMS OF DISEASE. There are few more interesting or more obscure chapters in pathology than that which relates to the affinities and antagonisms between different diseases, and their power of modifying, either favorably or unfavorably, each other's normal course. The subject is worthy of more attention than it has hitherto received, inasmuch as its thorough elucidation would certainly throw much light upon the etiology of disease and give definiteness to our conceptions regarding the mode of operation of morbid germs. We refer to such problems as, Can two specific constitutional diseases co-exist in the same subject? Presuming such co-existence, of which, in contravention to the teaching of Hunter, there can no longer be any doubt, Is the tendency of two such diseases to neutralize or to aggravate each other? What bearing upon prognosis and treatment has the supervention of diphtheria upon typhus, for example, or scarlatina upon enteric fever? Does the heavy burden of tuberculosis predispose to any other specific malady, or confer an immunity, comparative or absolute, from such? Questions of this kind are of great theoretic interest and considerable practical importance, but the evidence upon the subject and the literature dealing with it are still scanty.

The fact that Hunter taught the impossibility of two specific fevers co-existing is, at all events, presumptive proof that such co-existence is rare; but that such cases occur is no longer doubtful, and it would appear that any two of the exanthemata may run a simultaneous course in the same subject. Murchison has recorded eight cases in which scarlatina supervened upon enteric fever, three cases of diphtheria co-existing with typhus, and six cases in which typhus and enteric were present in the same patient at the same time. These observations have been confirmed by Peacock, Gairdner, Mac-lagan, and others, and the fact of such co-existence is no longer denied. Its import, however, is yet by no means clearly defined. It shows, at all events, that the morbid processes set up in the blood and tissues by the ingress of different specific germs do not tend in any decided degree to neutralize each other. Thus, scarlatina can certainly appear in a patient suffering from enteric fever, run its usual course, with typical symptoms, and subside, leaving the enteric to pursue its career. There does not, on the other hand, appear to be much evidence, if any, that the co-existence of two specific fevers multiplies the patient's risk in any way that might perhaps have been anticipated. A large majority of the patients simultaneously affected by two such diseases have undoubtedly recovered. If we can trust the very scanty evidence available on the subject, the co-existence of enteric and scarlatina, or of enteric and typhus, is much less grave than the co-existence of diphtheria and typhus, but the statistics are insufficient to warrant any definite conclusions.

The relation of the bacillus of tubercle to other specific germs opens up a wide field of controversy, and suggests many problems which still await solution. Let us look at its relation to three other specific maladies, viz., syphilis, enteric, and ague. The precise relation of phthisis and syphilis has given rise to much controversy, but the tendency of all recent investigation has been to regard many cases of destructive pulmonary disease in syphilitic subjects as the result of the breaking down of specific deposits rather than of the presence of tubercle. There seems, on the other hand, very little doubt that the debilitating effect of a prolonged attack of syphilis does, as might have been conjectured from analogy, powerfully predispose to the development of phthisis. We are thus driven to conclude that the presence of the syphilitic virus does not protect from the invasion of tubercle,

and probably, on the other hand, only predisposes to such invasion in so far as it injures the general health, and so reduces the power of resisting disease.

As regards phthisis and enteric, it has been held that patients suffering from well-marked phthisis rarely contract enteric, although it is not doubted by any one that prolonged cases of this fever are in many instances followed by the development of phthisis. The latter fact is quite in accord with analogy; the former, if true, would be an instance of that antagonism between different morbid poisons of which the evidence appears so scanty. It was long taught quite confidently that a strong antagonism exists between tubercle and ague; but this theory though supported by such authorities as Schonlein and Boudin, has shared the fate of so many unproved assumptions. Hirsch has definitely shown that, whatever color may have been lent to this view by limited local experience in various districts, it is in no way supported by the results of a wide survey of all the available facts.

It would thus seem that we know but little of the inter-relations of specific morbid conditions, and that many theories once confidently advanced on the subject have been compelled to give way under the pressure of accumulating experience. On the whole, it is encouraging to note that the development of a fresh specific disease in a patient already affected is, at least, a less untoward contingency than might have been feared. Another conclusion which the facts amply justify is that, while the co-existence of two specific diseases is unquestionably rare, it is not so rare that we need hesitate to diagnose such co-existence where the evidence for it seems fairly conclusive.—*Ibid.*

A CONTRIBUTION TO THE PATHOLOGY, SYMPTOMS, AND TREATMENT OF ADHERENT PLACENTA.—Few complications of the third stage are more disliked by the obstetrician than adherent placenta. While not now the bugbear it was in former times, yet the risks of hemorrhage and septic mischief make it still formidable, although, fortunately, the latter complication is rare and thoroughly preventable. We are not yet in a position to explain the pathology of this complication. Indeed, to do so in any instance would require such an extended knowledge of the case before conception and after labor as must necessarily be rare. I believe that obstetricians are to blame in not more thoroughly examining the shed placenta in adherent cases,

although it may be urged that the mischief is probably in the spongy layer and next the external wall. Granting even this, we do not as yet know the microscopic anatomy of such cases as we ought.

My attention has been directed to this subject from my very good fortune in obtaining a remarkable specimen of an inverted third stage uterus with the placenta adherent. As the microscopical anatomy of the specimen is interesting, and seems to me to partially explain such a complication, I have brought it before your notice to-night along with some remarks on its clinical aspects.

In examining this specimen, I did so by making microscopical sections of the entire thickness of the uterine wall and placenta by the celloidin process, so as to ascertain the difference of structure and arrangement in the serotinal layer as compared with a normal third stage uterus also with the placenta attached.

In the normal specimen we can recognize the following parts between villi and uterine wall:

1. Where the serotina and villi meet we have a band of dense tissue, which stains more deeply, and is apparently formed by a blending of villi and serotinal tissue. Owing to its density its exact structure is difficult to make out accurately, but it is probably connective tissue, and processes from it pass up between the villi forming the partitions between the lobes. Occasionally one sees in it some of the cells of the large-celled layer.

2. The large celled layer, sharply differentiated from the former, and made up of large endothelial-like cells, with nucleus and nucleolus. Scattered through this layer are many nuclei which stain deeply with logwood.

3. The spongy layer. This is a broad, well-defined layer, with large spaces lined by perfect columnar epithelium.

4. A much less meshy layer lying on the uterine muscle.

The contour of the muscle is not flat, but toothed.

In the sections of the adherent placenta the same structures can be made out, but *the mesh-work or spongy layer is much less marked, the spaces are markedly smaller, and in none of them can epithelium be detected.* There is no evidence, however, of chronic inflammatory affection—a point on which I had the valuable advice of Dr. Woodhead. The cause of the non-separation here depended apparently on the defective development or pathological condition of the mesh-

work or spongy layer, where the normal plane of separation for the placenta lies. How this has happened I am unable to explain, but the way in which it prevents a separation is too evident to require special remark.

Cases of adherent placenta vary much in their degree, and range from those where no hemorrhage accompanies the third stage, and where the separation of the placenta is easily performed by the hand, up to those where there is profuse hemorrhage, sometimes proving rapidly fatal, as well as those where separation is effected manually with the greatest difficulty even by the most skilled, and where the patient runs grave risk of septicemia. A clinical classification of adherent placenta, therefore, seems to me a requisite, and I submit the following as one based on the gravity of the case, and thus giving an idea of the prognosis:

1. Cases of total adhesion, unaccompanied by hemorrhage, where the separation of the placenta manually is easy, and is accomplished in the normal plane of separation.

2. Cases of partial adhesion high up in the uterus, where the placenta is separated in its lower part, often accompanied by serious hemorrhage. The upper adhesion is extensive.

3. Cases of adhesion low down, the placenta being separated above, not usually accompanied with hemorrhage.

4. Cases of very perfect adhesion, usually accompanied with little hemorrhage, but where separation is effected manually with great difficulty. The placenta is usually separated where the villi and serotina meet, and thus the uterus is left with the usual deciduous layer of the serotina still adherent, and often with portions of the fetal placenta attached.

This classification is of course a sharp one, and combinations of the varieties often occur. The first class is the typical and easy one. The patient has probably had a previous endometritis, has a slow second stage, and then a third stage where the placenta is not separated and expelled in the usual time. I have noticed this slow second stage occasionally, and usually set it down to ineffective uterine pains owing to the adhesion preventing proper uterine retraction. During the third stage the uterus may contract irregularly, developing nodules, as it were, in its contour. As the placenta is not expelled within three quarters of an hour, and is still in the uterus and unseparated, the obstetrician makes up his mind to separate manually—a procedure easily accomplished. I need

not give the details of this, but remark that the patient must be chloroformed, the vagina douched with corrosive sublimate (1 in 3,000). The dorsal posture is the best, and both hands are employed, the outer one to steady and depress the uterus as required. The separation of the placenta is best effected from below up, the entire separation being finished before expulsion is brought about. Sometimes confusion to the inexperienced operator is caused by his passing his hand within the membranes instead of keeping outside them. That an antiseptic uterine douche be used after full expulsion, goes without saying.

The second class of cases gives by far the most serious complication at the time. Blood pours from the relaxed uterine wall where the lower part of the placenta is separated, while the attachment above hinders uterine retraction. The attendant, despite all care to secure retraction by legitimate grasping and friction of the uterus, by hypodermics of ergotin, and the use of the hot douche, fails, and unless the placenta is promptly separated manually, so as to remove the cause of inefficient uterine action, the case may speedily become serious. Cases of ordinary flooding so readily, as a rule, yield to the usual means given above, that manual removal of the placenta is quite unnecessary interference. I think, however, that we err in waiting in this class of adherent placenta before resorting to separation by the use of the hand. No doubt the mistake can be rendered harmless by antiseptics; and further, the advice given here may be abused by the inexperienced, but experience will correct the error of undue meddling. I wish, therefore, to urge caution in this instance, viz., the attendant must always, in a flooding that looks threatening, remember the possibility of this dangerous upper adhesion of the placenta with the lower part separated. The greater the adhesion above the greater the risk.

The fourth class is not accompanied by flooding, but the union of uterus and placenta is so dense that separation is a matter of immense difficulty. The placenta in such cases is separated where the villi and serotina blend, and the separated placenta is practically the fetal portion with amnion and chorion. This is the case where septicæmia is to be feared. The uterus is left lined by a layer of dead tissue, affording a nidus for infection and exposing the patient to the gravest septic risks. Such require most stringent antiseptics during the puerperium, and the immediate use of the intra-

uterine douche if any threatening of mischief arise.

Separation of the placenta when adherent may occur, therefore, in the following planes: (a) Where villi and serotina blend; (b) in normal trabecular layer; (c) even at a superficial distance below muscle, usually only partial.

In conclusion, I would urge a more systematic microscopical examination in all cases of adherent placenta, especially where any superficial muscle is removed.—*Dr. D. Berry Hart, Edinburgh Med. Journal.*

SKIN-GRAFTING ACCORDING TO THIERSCH. Reverdin's important discovery of skin-grafting in 1870 soon found its application in hospital practice, but lately it has fallen into disuse on account of two faults, one an after-contraction of the skin-covered granulation surface, the other is a separation of the healed skin.

Thiersch states that the healing of a granulating surface depends on two factors, viz: first, in the changing of the soft succulent blood-carrying granulation papillæ into the bloodless dry cicatricial papillæ, a result which brings about a diminution of the surface and the drawing together of the neighboring parts; second, a covering over of the contracted papillæ with epidermic cells. Both of these factors, the contraction of the wound and the growth of the pellicle, take place together within certain limits, and when these limits are reached the granulating surface remains stationary.

If skin be placed on granulations which have not attained their maximum of contraction the process keeps up under the transplanted skin, and there results the drawing together of the part with all the evils of cicatricial contraction.

If, on the contrary, the skin be applied to a granulating surface which has reached its maximum of shrinking, a further contraction will not take place, but the succulent granulations remain under the healed skin, and the slightest mechanical irritation is sufficient to stir up hemorrhages or exudations, this causing the falling off of the skin which has been placed over them.

If these theories be true, then both bad results of skin-grafting are in a measure due to the construction of the granulation tissue. Perpendicular sections show clearly two layers in granulating tissue, a lower layer, more or less dense, according to the age of the granulations and in which the capillary net-work occupies a horizontal po-

sition, and from this dense layer the vascular branches run out perpendicularly, and form the upper or warty layer.

This upper layer plays the important part in the shrinking process as well as in the insecurity of the result. On account of this, Thiersch proposed to remove this upper stratum before transplanting the skin. Professor Maas says that the important point for success is the way in which the freshening up has been done; it is not only necessary to freshen up at the edges of the ulcer, but, above all, it is important to remove thoroughly the upper layer, and to expose completely the lower one with its horizontal capillaries, and between this layer and the transplanted flap a thorough adhesion will take place which can never be disturbed by cicatricial contraction.

The way in which skin-grafting is carried out in the Leipsic Clinic is as follows:

Complete disinfection of the part from which the skin is to be taken (any disinfectant may be used, but during the course of the operation a 6-per-1,000 sterilized salt solution is employed), then in the granulating wounds all the soft granulations are scraped away with a sharp spoon, the bleeding surface irrigated with the salt solution, sponged, covered with protective and compressed for five or ten minutes till hemorrhage has ceased. It is important that the right stage of granulation development should be reached before operating. The results are best when the granulations are about six weeks old, and their growth has been limited by repeated cauterization and compression. When the wound is thoroughly prepared the skin-grafting begins. The skin of arm and thigh is most often employed.

The skin, free from fat, must be well stretched by the left hand, the right hand carries a razor with a long, wide, and concave blade. The razor is held flat and is slowly drawn with a sawing motion through the upper layers of the skin. During this process the knife must be kept moist with the salt solution. The transferring of the grafts from the knife to the prepared surface takes place immediately, the blade is laid on the wound and the edge of the graft is drawn over on to the wound by means of a probe, and as the blade is withdrawn it slips into place. The position of the graft may be corrected at will either with a probe or small brush. The flap may also be shortened if necessary. The complete area is to be covered with strips of skin, and these strips should overlies the edges of the wound

and come together as close as possible, even overlapping each other slightly. The skin is gently pressed in place with a spatula. The dressing to be applied should protect and maintain the skin in its new position. The results are better when a moist dressing which is changed daily is used. The neighborhood of the wound is smeared with oil to prevent the dressing from sticking.

The grafts are covered with a strip of protective, soaked in salt solution, over this comes a pad of cotton, also moistened with salt water—this pad is covered by a large piece of protective—then comes another pad of dry cotton, and all is held in place by a cotton bandage, over which a dextrine bandage is applied to prevent slipping. If a dry dressing is to be employed, an iodoform one is the best. The places from which the skin has been removed are covered with iodoform dust, a dry dressing applied, and left for one or two weeks.

The changes which are to be observed in the grafts within the first few days are as follows: If they are of a pinkish color, success is pretty certain; if white, they will drop off in a few days; blood under a graft gives it bluish color, endangers the healing process, but does not always lead to suppuration. It is possible for various forms of bacteria to find entrance into the wound and prevent healing; to do away with this danger, the dressing should be changed every day during the first week, and the surface irrigated with sterilized salt water.

If the wounded surface is not covered with grafts there appears on their free border a fibrinous exudation, and separation of the grafts begins, the healed ones detach themselves, or small epidermal blisters filled with pus appear on the healed spots and form small ulcers, which gradually increase in size.

It also happens that the super-imposed skin is broken through from below by granulations, and in this manner disappears, at least temporarily; but later, when the granulations recede, the epidermal islets are again seen. This the author does not believe to be due to an infectious process, but thinks it is because the grafting has been done too soon.

Syphilis may prevent the grafts from healing. The author analyzes a series of forty cases, in which transplantation was carried out seventy-eight times, seventeen times on fresh wound surfaces, sixty-one times on scraped granulating surfaces. In fifty-eight times the healing succeeded perfectly, twelve

times it was incomplete, and eight times it was a total failure, and the proceeding had to be repeated.

In summing up he lays stress on the following points: Careful disinfection of the hands and instruments, newly prepared sterilized salt solution (6 per 1,000), proper choosing of time of operation, thorough hemostasis, most complete covering possible of the wound with strips, immobilization of the part, careful bandaging, daily changes of dressing, accompanied by thorough irrigation.

The results are better on scraped granulation surfaces than on loose or connective tissue (fascia, periosteum); glandular and muscular tissue give pretty good results. Spongy bone tissue and exposed tendons yield no permanent result. Adhesion of grafts has never been obtained on compact bone.—*F. C. Husson, Annals of Surgery.*

**PUERPERAL FEVER.**—The recognition of the importance of microbes in puerperal fever has led many to regard as obsolete the old classification into autogenetic and heterogenetic puerperal fever; and doubtless it is now the most important lesson to impress upon practitioners that all puerperal fever is, in a sense, heterogenetic, since the germs must have come originally from without. Yet it remains a question of vital importance whether microbes constantly or commonly present, or only rare and virulent ones, are the active agents; and again, whether common microbes, which are generally innocuous, can be so cultivated in fertile soil as to become virulent.

Experience has shown that, in abdominal surgery, it is not of so much importance to destroy microbes as to avoid leaving any nidus for them in the shape of damaged tissue or sanguineous effusion. It should not be forgotten that the same principle has its application in midwifery. Not even the use of the most fashionable antiseptic of the day would be a sufficient compensation for allowing unnecessary lacerations of cervix or perineum, for omitting to secure good contraction of the uterus, for leaving a ruptured perineum unsewn, or for bruising tissues needlessly in operations. But the special success in lying-in hospitals of the one particular antiseptic, perchloride of mercury, beyond all others, seems to indicate that the balance of importance is somewhat different in midwifery and in abdominal sections; and that, in lying-in hospitals at any rate, there are likely to be virulent microbes which ought to be destroyed.

Whether the same principle applies to the prevention of sporadic cases of puerperal fever

in private practice can only be ascertained by a trial of antiseptic midwifery by all practitioners on a scale which has not, I believe, been attempted in this country. The use of perchloride of mercury for internal douches, as employed in lying-in hospitals, would indeed probably involve the risk of doing more harm than good through its occasional poisonous effects. Fortunately, there is reason to believe that this is not the most important part of antiseptic midwifery. We are told that a drop of normal mucus from the cervix of a woman at the end of pregnancy, when drawn with a sterilized platinum rod across nutrient jelly, may produce as many as two hundred colonies of various forms of bacteria. All who have tried to render the vagina aseptic, in the sense of being sterilized, for gynecological operations, will know how difficult this is to accomplish.

This is brought out strikingly by the recent researches of Steffek. No number of douches of perchloride of mercury will render the vagina aseptic at the end of pregnancy. To effect such a result it is necessary to scrub vigorously with two fingers not only the vagina but the inside of the cervix, while a douche of at least a liter of the antiseptic is being used. Even this produces only a momentary effect, unless it is followed up afterward by the use of at least four or five douches at intervals. It may be doubted if the vagina is ever sterilized so as to satisfy the more severe practical test of leaving therein for several days a glass tube containing bloody discharge without decomposition occurring in it.

I think we may conclude that the microbes commonly present are generally innocuous, and that, in lying-in hospitals at least, and probably elsewhere as well, what has to be done is to prevent the entrance of virulent ones. I would venture to urge on all practitioners the importance of providing for themselves and the nurse the most efficacious antiseptic known, namely, perchloride of mercury, of a strength not less than 1 in 1,000. This should be used for hands, catheters, and any cotton-wool or sponges used for external washing; disinfection of the accoucheur's hands being the most important thing of all. Even the most complete unbelievers in antiseptics, if any such remain, must admit that this can not possibly do any harm, and involves merely a little extra trouble. One practical detail is of importance. No one should trust to any tablets or powders of perchloride of mercury without testing them in dilute solution in the water of the district. It is obvious that, if the slightest milkiness is produced, it is impossible to tell how much of, or whether any of, the antiseptic remains efficacious. A concentrated solution made with a

little glycerine and dilute hydrochloric acid in distilled water is more reliable, and has the advantage of the increased efficacy which the acid gives to the antiseptic in the presence of organic matter. The trouble of carrying a liquid is hardly greater than the trouble of dissolving tablets. As regards vaginal douches, my own view is strongly in favor of their routine use, with some efficacious but less poisonous antiseptic, such as carbolic acid; but I admit that this matter is open to difference of opinion, and that they are better omitted in normal cases, unless they can be used regularly by a competent person.

In most of the States of Germany stringent laws have been enacted for the use of antiseptics by midwives; and there is a general impression among German obstetricians that the conveyance of puerperal septicemia has much diminished in consequence. I am informed, however, by Professors Leopold and Sanger, that in Saxony, at any rate, there has not as yet been manifest any appreciable diminution of the general puerperal mortality. Nearly one half of the deaths in childbed are still ascribed to septicemia. Fischel infers, from Dohrn's statistics, that the laws relating to midwives have not yet produced an improvement in childbed mortality in any German State as a whole, though they may have done so in individual towns. It is an obvious consideration that no laws can enforce the efficient use of antiseptics, however much they may prescribe them. We may, at any rate, console ourselves with the reflection that, unless death-registration is more delusive in England than abroad, our childbed mortality remains lower than that of either Germany or Austria.

Though the returns of the Registrar-General in England are thought not to indicate the whole mortality, they may afford some basis for comparison of different periods. They seem to show some improvement of late. The mean mortality of childbirth for 39 years, 1847-1885, is given as 4.82 per 1,000; but for the last ten years of that period as only 4.45 per 1,000. Yet as regards puerperal fever the report is not altogether satisfactory. Since the year 1881, when a more stringent system was introduced by the registrar, of sending for further information as to previous parturition, whenever the death of a woman was returned as due to peritonitis, considerably more than half of the total mortality in childbirth is set down to puerperal fever, the minimum for the years 1881-1885 being 2.58 per 1,000. I think this affords ample ground for urging a more stringent use of antiseptics.

Meanwhile, a valuable experiment may be tried in the maternity charities of our great

medical schools, the conditions in which approximate to those in private practice. In the charities of Guy's and St. Thomas' hospitals, and, I doubt not, in others also, the use of perchloride of mercury is already being enforced. It must not be forgotten that the results here obtained, without any constant or systematic use of antiseptics, already equal or surpass even the best results of antiseptics in lying-in hospitals, and have steadily improved. Thus, the mortality for the last ten years in the Guy's Charity was 3.4 per 1,000, for the preceding twelve years 4.4 per 1,000, for the first twenty-one years recorded 7.1 per 1,000. But here, again, more than half the deaths are still set down to puerperal fever. If a material reduction of this mortality through a more stringent antiseptics can be proved, it will be an enormous stimulus to the adoption of similar precautions by all practitioners.

Another problem not yet fully solved with regard to puerperal fever is its relation to zymotic diseases. Though it has been a widespread opinion in this country that puerperal fever may originate from the infection of scarlatina, this opinion must be regarded as shaken by recent evidence. It is worthy of note that recent researches attribute the secondary lesions of scarlatina itself, such as those of the ear and the joints, to a mixed infection of another species of microbe. It is possible that in the theory of mixed infection may be found some solution of the problem. Dr. Boxall's account of scarlatina in the General Lying-in Hospital suggests the hope that, if complicating septicemia can be excluded, scarlatina may lose much of its terror for the lying-in woman. Yet further evidence is to be desired. For a single epidemic may be of mild type; and even long before the days of antiseptic midwifery a series of nine cases of scarlatina in Queen Charlotte's Lying-in Hospital was recorded by Brown, in which there was no mortality, and from which no septicemia resulted. I would suggest that records of erysipelas occurring in lying-in women are especially desirable; for erysipelas has been thought to be yet more closely allied to septicemia and puerperal fever than scarlatina, and yet it is a zymotic disease, and is considered to depend upon a definite and discoverable microbe.

We have still to look to bacteriologists for some light upon the infectious character of puerperal fever. We hear of *staphylococcus pyogenes aureus*, *streptococcus tenuis*, and *staphylococcus pyogenes albus* being found. But these are comparatively common microbes, found frequently in mild and local suppuration. Unless they can acquire virulence by the growth in the puerperal woman, it is diffic-

to understand that they can account for such intense infection that, in the days before the need of caution was recognized, instances occurred like that of the midwife who, within one month, delivered thirty-one women, of whom seventeen died of puerperal fever.—*Dr. A. L. Galabin, British Medical Journal.*

**NASAL OBSTRUCTION: EXAMINATION OF THE NOSE.**—Until quite recently the examination of the nose has been either entirely neglected or else performed in such a superficial manner that the information afforded by it has been of little value. At the present time the examination of the nose is done in a thorough and systematic manner.

First of all, the patency of the nasal cavities should be tested by directing the patient to shut his mouth and breathe for a few minutes through his nose; each side may be tested separately. A good idea of the presence or absence of obstruction may be obtained by getting the patient to smoke a cigarette and blow the smoke out through the nose, any inequality of the patency of the two sides then becomes very obvious. But we must be cautious not to infer that a patient can inspire through the nose because he can expire through it. We often see cases in which, during inspiration, the projecting ridge on the outer wall of the nose, at the junction of the vestibule with the anterior nares, falls in like a valve, and yet produces no expiratory obstruction.

We then examine the nasal cavities from the front by means of anterior rhinoscopy. The parts must, if necessary, be thoroughly cleaned by means of sponging and mopping out with small pellets of cotton-wool twisted on a probe.

A speculum is then introduced into the anterior nares. When the head is held horizontally, the most prominent object visible is the inferior turbinated body, especially if swollen, and a large part of the septum can also be well seen. When the head is thrown back, the middle turbinated bones are seen; and when the head is depressed, the patency of the inferior meatus is ascertained, for when there is no obstruction one can see a long way back, sometimes even far enough to see the eustachian orifices; but sometimes, owing to the passage being crooked, we can only see a short distance, although here may be no obstruction to the passage of air.

Certain cases require that we should inspect the posterior nares; this proceeding is called posterior rhinoscopy. It is performed by passing a small mirror behind

the soft palate, and inclining it at such an angle as to bring the various parts of the posterior nares into view. By this means we can see the posterior surface of the palate, the posterior border of the septum of the nose, the extremities of the inferior and middle, and sometimes the superior turbinated bones, and on the lateral wall of the naso-pharynx may be seen the openings of the eustachian tubes and part of the fossae of Rosenmüller.

We also have another method of examining the posterior nares and naso-pharynx: this is by palpation. When deemed necessary this examination should be performed in some systematic way, such as that recommended by Mr. Walsham:

"The finger, presuming the right hand is used, should be first rapidly swept over the right eustachian orifice, then carried forward into the right choana, and the posterior end of the turbinated body examined. It should then be passed over the septum into the left choana, thence to the left eustachian orifice, and finally swept from left to right over the vault and back of pharynx, investigating the condition of the adenoid tissue in that situation and the pharyngeal tonsil."

This method of examination should be avoided when possible, as it is most unpleasant to the patient. It is, however, advisable that students should accustom themselves to the feel of these parts in the dead body, that they may the more readily recognize their diseases in the living.

If we now consider the nose from an anatomical point of view, we shall find it convenient to divide the cavity into the meatuses of the nose and the naso-pharynx.

It is usual to describe three meatuses of the nose on each side, but in this connection it is only important to consider the middle and inferior.

The meatuses are bounded internally by the septum, and externally by the turbinated bones, and we shall find that causes of obstruction may be met with in either of these situations. Let us now turn our attention to these causes, taking the above brief anatomical description as our basis of classification.

**Turbinal Obstruction.** Under this head let us first consider turgescence or erection of the inferior turbinated body. This is a cause of nasal obstruction familiar to every body, for who has not had a cold in the head and experienced the uncomfortable sensation of a blocked nose? The cause of this blockage may be obscure to those who

are not familiar with the structure of the mucous covering of the inferior turbinated bone; but if we examine it carefully and notice the large amount of erectile tissue which it contains, it becomes apparent at once how capable it is of filling with blood and swelling to such an extent, during an acute catarrh, as to effectually block the nose. In an ordinary cold this condition is, of course, only temporary, but after repeated colds, and as the result of breathing air charged with dust and varying greatly in temperature, the turbinated bodies become permanently swollen, and the erectile tissue covering them loses its tone. This condition is important, because the fullness and consequent swelling of these bodies depends largely upon gravity, when the inherent contractility of the tissue has been lost; the result is, that during the daytime, the head being the highest part of the body, the turbinals are more or less empty and produce no obstruction; but at night, when the head is lowered, nasal respiration is impossible as the sleeper lies upon his back, the posterior ends of both turbinated bodies swelling up to such an extent as to block the posterior nares. The truth of this statement may easily be tested by lying flat upon the back and trying to breathe through the nose; it will be found that the respiratory act will become more and more difficult until at length it is well-nigh impossible; now turn over and lie upon the right side, and in the course of a few minutes the left or upper side will become clear while the right or dependent side will remain blocked; again turn over on the left side and the right will become clear and the left side will get blocked. In people with a perfectly healthy nose this experiment will fail, but a perfectly healthy nose is such a rare thing that I feel confident that the great majority of people who try this experiment will not be disappointed.

Some people find that they can only sleep on one side, and this is usually because one side of the nose is permanently obstructed by some deviation of the septum or other cause, so that if they sleep with the good side dependent, both nasal cavities become blocked.

If we make an examination in a case of turgescence of the turbinated bodies, we shall see, on looking into the anterior nares, a red rounded swelling projecting from the outer wall of the cavity, and perhaps coming in contact with the septum, so that it may be difficult at first to know which way the meatus goes. If we touch this swelling with

a probe we shall find that it feels like a bag of fluid, and is easily indented, and if we spray the part with a ten-per-cent solution of cocaine, the swelling will in a few seconds be very greatly reduced.

In the ordinary head cold, great relief will be obtained by spraying the anterior nares with a ten-per-cent solution of cocaine; the nose, which may be absolutely blocked, will become quite clear in a few minutes, and will remain so for about a couple of hours, when the spraying must be repeated. When the swelling of the turbinated bones has become chronic, the nasal cavities should be rendered anesthetic by cocaine, and the point of a galvano-cautery wire introduced into the dilated tissue for a distance of half or three quarters of an inch; this produces coagulation and subsequent shrinking, so that after a few weeks the obstruction is removed.

In many cases we find the mucous membrane covering the turbinated bodies thickened and hypertrophied. This condition is often most pronounced at one of the extremities of the inferior turbinated body. It is distinguished from mere turgescence by its feeling harder when touched with the probe, and by cocaine having no effect upon its size. In such cases the most satisfactory treatment is to remove the hypertrophied lump with the cold wire snare or the galvanic *écraseur*. When the hypertrophy affects the whole surface equally, its thickness may be diminished by drawing lines along it with the galvano-cautery wire.

Nasal polypi grow almost exclusively from the middle turbinated bone. Their symptoms are so well known that I think I need hardly refer to them. With regard to treatment, I would only say that the old method of blindly introducing a pair of polypus forceps, and pulling the growths out, should be unhesitatingly condemned. The best way to remove them is to render the parts anesthetic by cocaine, and then introduce a cold wire snare and slip the noose over the growths and so cut them off.

*Septal Obstruction.* Various morbid conditions of the septum are fertile causes of nasal obstruction. Deviation of the septum may be acquired or spontaneous; an absolutely straight septum is a comparatively rare thing. The deviation may be limited to the triangular cartilage of the nose, or it may involve the bony septum. It is very rare, however, to find the posterior edge of the septum deviated; sometimes the deviation is so great that it may touch the outer wall of the cavity, and sometimes the de-

lection is sigmoid in shape, so that it obstructs both sides of the nose. In cases of spontaneous deviation we frequently see an overgrowth of bone or cartilage on the convex side. The treatment of deflected septum is so difficult and unsatisfactory, that I think it better in all cases to endeavor first of all to establish a wide enough passage by diminishing the size of the turbinated bodies on the affected side; should this fail, an attack may then be made upon the septum.

*Naso-pharyngeal Obstruction.* Adenoid vegetations are by far the most frequent and important cause of obstruction in the naso-pharynx. They are met with almost entirely in children, and are prone to produce the most serious effects. They consist of hyperplastic masses of the lymphadenoid tissue which is so abundant in the naso-pharynx. The chief symptoms which they produce are a vacant expression of countenance, a constantly open mouth, collapsed nostrils, snoring respiration, a "dead" quality of voice, and deafness more or less complete. They are frequently found in conjunction with chronic enlargement of the tonsils, so frequently indeed, that an examination of the naso-pharynx is imperatively called for in every case in which enlarged tonsils are discovered. If the finger be passed up behind the soft palate, it will be found that the landmarks which are easily palpable in the healthy naso-pharynx are more or less completely obscured by soft masses of various sizes projecting into and sometimes completely filling the cavity. It is best to conduct this examination under chloroform, and to proceed to remove the vegetations at once. This is best done by means of Löwenburg's forceps passed up behind the soft palate. With this instrument the larger masses are quickly pulled away, the smaller portions being subsequently scraped off with the finger nail. The bleeding is always free, sometimes alarming, but, with the assistance of an experienced chloroformist, never dangerous.

The after-treatment consists in keeping the patient indoors and out of the cold for a week, and in getting him subsequently to breathe through the nose, either by means of persuasion or by tying up the mouth.

Space will not permit me to say more, but I would recommend those who wish to know more of this important subject to read Mr. Butlin's admirable paper on "Adenoid Vegetations" in the *St. Bartholomew's Hospital Reports*, vol. 21.—*Edmund Roughton, B. S., London Practitioner.*

AN ADDRESS ON SYPHILIS.—This address was delivered by Dr. Henry Fitzgibbon at the opening meeting of the Surgical Section of the Royal Academy of Medicine in Ireland, session 1888-'89. A short account of the history of syphilis is given, where the author adheres to the hypothesis of the ancient origin of syphilis. In considering the manner of invasion of syphilis, he has only time to speak of that by contagion. He believes that the chancre and chancreoid are distinct forms of disease, but that gonorrhea may on rare occasions be the sole primary lesion of syphilis. A case is noted where infection by contact and direct absorption, or *bubon d'emblée*, was apparently the only explanation of the infection. No abrasion or excoriation whatever was found. Another similar case occurred to him.

The following is an interesting case of syphilis of the innocent. A rich banker, whose reputation for propriety of conduct was his greatest pride, contracted a Hunterian chancre upon his lower lip. With pardonable indignation he told his family physician that he was a liar when he announced to him the nature of the disease. It subsequently transpired that he had inoculated his lip with his finger when counting a roll of bank notes which had been recovered from a prostitute who had stolen them from one of his clerks. The woman had concealed the roll in her vagina. A more painful case was that of a young lady, only fourteen years of age, who unaccountably developed a profuse papular syphilide. She had an induration on the right thigh a little above the knee. This, she said, was where the crutch of her saddle had cut her six weeks previously, when taking a riding lesson. The recent abrasion had then become infected by virus from the seat of a closet at a railway station. Among the poor, he thinks, the *acarus scabiei* often conveys syphilis. Chaste mothers and sisters have been contaminated by the kiss of a dissipated son or brother. Healthy children have been infected by nurses. Midwives have spread the disease. Hardy states that a specialist in Paris inoculated forty or fifty persons with a eustachian catheter. Vaccination is supposed to be a source of public danger, but it reflects credit and honor on our public vaccinators that for many years contamination of healthy children in this way is practically unknown. Preventive treatment by C. D. Acts is strongly insisted upon. By the judicious and rational use of mercury, by enforcing temperance, by regulating digestion, by prohibiting exposure to extremes of temperature, and by the proper administration of baths, we know now that syphilis can, like other eruptive fevers, be cured and wholly eliminated from the system. The

proof of this is the fact that an individual can have a second attack of syphilis. Zeissl's dictum "that a man who once has syphilis has it forever, and that his ghost after death will still be syphilitic," is proved to be untrue.

Dr. Keyes, of New York, read a paper on "The Curability of Urethral Stricture by Electricity." Observations were made on six selected cases favorable for testing the method. Two were treated by himself, three by Dr. Fuller, his assistant, and one by Dr. Newman in Dr. Fuller's presence. In all cases the result was non-success. Dr. Keyes believes that the claims made for the method are not supported by clinical demonstration.

Dr. F. S. Watson: As a contribution coming from an entirely independent source, I would like to mention a little experience with electrolysis in urethral stricture of my own. The results were similar to Dr. Keyes'. The number of cases was six, and all the rules laid down by Dr. Newman were observed. In no one of the cases was there a successful result. In the best case a sound two sizes larger than could at first be introduced was passed at the end of several weeks' treatment. In the first case, after electrolysis had been resorted to without success, the stricture was cut.

Dr. L. B. Bangs: I have had some experience with the treatment of stricture by electricity. After having gone a certain distance with it I got so disgusted that I gave it up. Nevertheless the impression seems to be gaining ground, not only in the profession but also among the laity, that we now have a means of positively curing stricture without causing pain. I believe it is altogether a false impression.

Dr. F. R. Sturgis: My experience was one dating back some years ago, when this treatment first came up. I found that it did much more harm than good. But there resulted so much pain and bleeding, and I was so fearful of doing damage, that I gave it up since no good came from it.

Dr. Tilden Brown, by invitation: I need hardly say that I have listened with interest to the reading of the paper, particularly as it confirms experiments made by myself. The only thing which occurs to me as confirmatory evidence of what I consider the utter futility of the method is the fact that after I had read my paper, which has been alluded to, Dr. Newman kindly came up and spoke to me, and a gentleman present suggested that Dr. Newman take the second case which I reported, which had been so pronounced a failure, and treat it. He objected on the score of being too busy. We urged him, and assured him the full fees would be paid for the treatment, but despite that fact

he declined to accept the case. I told him that if he would take the case and cure it I would devote all my future to extolling the method, but it was fruitless.

The President (Dr. Keyes): I can only say, in closing the discussion, that it is a great pity to have to raise the question at all, but the method is gaining credence in the mind of the public, and some medical gentlemen have come out in favor of it. I have even seen a notice of some one curing strictures of the rectum by electricity. It is a sort of faith cure. I began the study of the method because patients came to me and wanted to be treated by electricity. I acknowledged ignorance of the method and indifference toward it, but I had no foundation for my non-belief, for no man should accept his belief second-hand; I had not made experiments. But now I have made them, with the results recorded in my paper.—*Journal of Cutaneous and Genito-Urinary Diseases.*

**SYPHILIS AS A NON-VENEREAL DISEASE.**—In the Journal of the American Medical Association, December 22, 1888, Dr. Bulkley remarks that three main groups or varieties of cases of non-veneral infection of syphilis may readily be made out, according as the inoculation takes place: (1) Among those having common relations, and through the bonds of common interest in domestic and industrial life; to this class the term *syphilis economica* has been given; (2) Among infants and those having to do with their care and nourishment, or *syphilis brephotrophica*; and (3) In connection with the various forms of body service, medical and surgical, or of like nature—*syphilis technica*. In each of these groups we will find a large number of subdivisions, amounting to over one hundred, representing different modes of communicating the disease which have thus far been recorded in literature. These divisions may now be considered a little more in detail.

1. *Syphilis Economica*. Infection may come from spoons, knives, forks, cups, glasses, and jugs. Tobacco pipes and cigars have been the means of transmission. Wearing apparel has conveyed syphilis; as also lin plaster; likewise bedding and toilet articles, syringes and tooth-brushes. No authentic case of infection from privy seats has been recorded. An opera glass and a cane have also conveyed the poison. Among trade glass-blowers and goldsmiths have each suffered from the blowing tools passed from mouth to mouth. Musicians have acquired the disease in a similar way, and a car conductor from a whistle borrowed from a syp

ilitic friend. Three furriers were diseased by the thread drawn through their lips. An artificial flower maker was infected through her handiwork, and an instance where tack nails passed from the mouth of one upholsterer with mucous patches to another conveyed the poison to abrasions caused by the nails is mentioned. Paper money and coins may also be mentioned as causes of infection. Kissing, next to the venereal act, is the most prolific source of propagation.

2. *Syphilis Bephotrophica*. Infants frequently spread the disease either to wet nurses or by means of their feeding-bottles. Scratches and tooth wounds inflicted by syphilitic infants have repeatedly given rise to chancres, while a large number of infants have received an extra genital chancre from the kissing and fondling of syphilitic adults.

3. *Syphilis Technica*. Physicians, surgeons, accoucheurs, and midwives have all been frequently infected in the pursuit of their profession, more especially the two latter classes. Chancres have also been produced on different parts of the face by the fingers of physicians and attendants conveying the virus. Physicians and midwives have also spread the disease from their own persons while attending patients. A rather curious mode of propagating syphilis innocently is found in the practice of removing particles from the eye by means of the tip of the tongue. In two small villages in Russia Tepljaschin found, among a population of 532 persons, no less than 68 individuals, 23 males and 45 females, affected with syphilis, about one quarter of them being under ten years of age. One half of the entire number had been infected directly by a female quack who had followed the industry of removing foreign bodies from the eye and treating trachoma with her tongue. The woman became infected in her calling, and pursued it while diseased, with the results mentioned. A number of single instances of the same method of infection have been recorded, two of which occurred in this country. Wound-sucking has given syphilis to the operator and also to the person operated on. Many cases have been recorded of infection from tattooing. Vaccination, ritual circumcision, transplantation of teeth, wet-cutting, minor surgical operations, eustachian and other forms of catheterization have all been reported as frequent sources of infection.

JABORANDI IN ERYSIPELAS.—The treatment of erysipelas by jaborandi leaves nothing to be desired. Jaborandi is as much of a specific as quinia in malaria. I have tried it in

three cases this winter, all of them severe. In one complicated with implication of the buccal and naso-pharyngeal mucous membrane in a pregnant female, where abortion was threatened, its effects were prompt, and the reduction of the temperature and all alarming symptoms immediate. In this case, its alkaloids were given hypodermically with morphia.

I also used it in a case of puerperal peritonitis, where I had reason to believe that erysipelas was the infective principle. The temperature came down very slowly, but the typhoid symptoms were improved immediately. The slow fall of the temperature I attributed to the excessive pelvic exudation, which bulged the posterior wall of the vagina, and pressed the upper part of the rectum firmly against the sacrum. I know the exudation was peritoneal, because in the sitting posture there was dullness and the impulse of fluid given to the hand in the lower part of the abdomen, above being tympanitic, and the dullness changing with posture. It was a primipara, with no history of ascites or edema previous to her confinement.

Her attendant, a very intelligent practitioner, informed me that there was no fluid to be detected during, or shortly after, her delivery, except what was contained in the uterus.

Of course jaborandi was not the only drug used in this case; morphia, whisky, digitalis, turpentine stupes, hot vaginal injections, and abundance of milk made up the treatment.

I visited her yesterday, March 11th, three weeks after her confinement and sixteen days from her first illness, and found all trace of exudation gone, but some tenderness about one of the broad ligaments yet. She is only taking a general tonic now (iron, quinia, and strychn.) and will soon be able to do her work. *Dr. A. G. Osterman, Medical Times.*

CIMICIFUGA.—Balfour (Lancet) relates several cases of nervous disease in which cimicifuga proved serviceable. A nervous, weakly young lady had suffered from dysmenorrhea since the beginning of menstruation, at the age of twelve years. After the failure of many remedies, ten minims of the tincture were ordered to be taken twice daily for several days previous to the expected menstruation, and continued throughout the period. Hot fomentations were also employed, and the patient confined to bed. Great relief was experienced from the first, and in a short time a dose or two at the beginning of the flow sufficed to keep the patient so free from pain that it has

become quite exceptional for her to be compelled even to lie down for a few hours.

In a case of severe spasmodic gastralgia, with dyspepsia recurring every few weeks, and attended with fainting fits, great improvement ensued when the patient's diet was regulated. She was kept for some days upon teaspoonful doses — every twenty minutes — of milk, two parts, to one of lime-water. Then she was allowed a raw egg with milk and sherry; then raw beef juice with bread-crumbs, pepper and salt. After some time the attacks of gastralgia returned and *cimicifuga* was given, ten minims of the tincture every eight hours, with complete success.

In a third case, hysterical neuralgia in a girl twelve years old, he gave ten minims of the tincture every six hours and ten grains ammonium bromide at bed-time, with mustard poultices over the ovaries, which were quite tender. Improvement followed at once, and, with the use of iron and change of air, a cure was effected.

*Cimicifuga* appears to be more popular in Europe than in America, although it is held in high estimation here as a domestic remedy. Many years ago it was lauded as a remedy in pulmonary consumption, and several cures were reported from its use. Stillé sagely concluded that these cases were probably of chronic bronchitis, but strangely overlooked the fact that, if this were true, we have in *cimicifuga* a gem of the first water, as chronic bronchitis is scarcely to be considered any more curable than tubercular phthisis. We have never succeeded, however, in curing the catarrhal affection with *cimicifuga*.

In chorea this drug has also a high degree of popularity among the laity. We have found it efficacious in several cases, but only when the fresh root was employed in decoction. In dysmenorrhea it has not proved as useful as gelsemium or as salol; but this may have been because the fresh root was not employed.—*Ibid.*

**TOTAL EXTIRPATION OF GOITRE.**—By Professor Vasily Razumovsky (Kazan, Russia). A somewhat anemic and meager woman, aged thirty-five, was admitted with a parenchymatous goitre of ten years' standing, and with complaints of the tumor occasionally causing severe paroxysms of dyspnea at night, and generally interfering with her breathing in any household work. The goitre was fairly movable and uniformly elastic, and had the size of a man's fist and an irregularly roundish shape. It reached from the hyoid bone down to the sternum, and involved the whole thyroid gland; the isthmus

and the right lobe, however, were much more enlarged than the left one. A total extirpation of the goitre was performed after Cocher's method under chloroform and antiseptic precautions, the operation lasting two hours. About thirty ligatures were tied, hemorrhage being but trifling. The after-course was most satisfactory, the highest temperature being 38° C. On the eighth day the woman got up to walk in the hospital garden. The wound soundly healed about the thirtieth day. For the first twenty-four hours after the thyroidectomy there was observed a singular intermittency of the patient's pulse; a strong beat was rapidly followed by a series of accelerated and faint pulsations and then by a long interval, after which a single strong beat could be felt again and soon. On the next day the curious phenomenon disappeared spontaneously, but the pulse remained quickened (110 to 120) for eight days. The tumor removed contained numberless small cavities with colloid matter. When seen, six weeks after the operation, the woman was free from all former symptoms as well as from all signs of cachexia strumapriiva. *Valerius Idleson, Annals of Surgery.*

**EXCRETION OF URIC ACID IN GOUT.**—In the course of a paper on this subject, Dr. Haig, after describing the effect of certain drugs in a case of gout, points out that arthritis can be produced not only by the acid in wines or beer, but by acids taken in other forms. Lead and iron, which have nothing further in common with acids than their effect on the solubility of uric acid, will give similar effects; and it can be further shown that when an acid is given, the excretion of uric acid in the urine diminishes hour by hour as the pains come on and increase, and that thus we can be certain that the pains are the result of the retention of uric acid in the system, the joints being one of the places in which it is retained. It has been already shown in former papers that the uric-acid headache is due to excess of uric acid in the blood, and that it is contemporaneous with its excessive secretion in the urine (the excess in the urine being an overflow from the excess in the blood, and varying with it); and it can be shown that as the joint-pains come on and increase, the excretion of the uric acid diminishes in the urine when acids are administered, the reasons being that the acids diminish the solubility of the uric acid in the blood, and lead to its precipitation in the liver, spleen, and kidneys. He lays it down as a general law that if the acids, iron or lead, cause retention of uric acid, they will cause an

attack of gout; and on the other hand, if the alkalies or salicylate of sodium cause a free excretion of uric acid, they will relieve or cure the attack. There are, however, reasons why these general laws may not be always obeyed. Acids may not cause joint-pains, owing to gastric disturbance, or because they are given in insufficient doses to counteract the alkali already in the stomach. Alkalies may fail for a similar reason—that they are insufficient to counteract the existing degree of acidity. Constipation probably plays an important part in causing the drugs to fail of their expected action. Intestinal irritation, by diminishing absorption, lowers the excretion of urea, and causes a fall of acidity, thus facilitating the excretion of uric acid; constipation probably has an exactly opposite effect, and it is generally accompanied by a rising acidity of the urine and a diminished excretion of uric acid. *St. Bartholomew's Hospital Reports*, vol. 24, *London Practitioner*.

**A NEW METHOD OF DRAINAGE IN SUPRAPUBIC CYSTOTOMY.**—By E. H. Fenwick, F. R. C. S. (London). The method advocated by Mr. Fenwick depends on the principle of the Sprengel pump, and is described by its author as follows: "An irrigating cat is placed on a chair at the bedside, and its tube, with a clip affixed to regulate its outflow, was dropped into the chamber under the bed. The drainage-tube from the bladder is connected with it at an acute angle. A continuous dribbling of water from the reservoir falling into the chamber sucked the urine from the bladder as fast as it collected there, and the patient is kept perfectly dry."

It is not claimed for this method that it is essentially superior to the other known methods, but in feeble old patients who are particularly liable to eczema or bed sore from continual soakage of the overflowing urine it is thought that it may prove of as much service as it did in the author's cases. *Illustrated Medical News*.

**TWO CASES OF SUPRAPUBIC LITHOTOMY IN BOYS.**—By Dr. Nikolai N. Rüsanoff (Novokhopersk, Russia). (1) A boy, aged three years. Having filled up the bladder with a warm boracic solution, Dr. Rüsanoff hooked the wall and made an incision between two hooks. At this stage there suddenly appeared in the narcotized child violent retchings which expelled the fluid from the viscus, while the latter simultaneously slipped out from the author's hands to sink into the abdomen. Being unable to make out the

incision, he made another and introduced a finger into the organ, but this time, to his utter consternation, failed to detect any stone therein; in fact, the bladder proved to be empty, though the presence of a stone had been established beyond doubt just before the first incision. Anyhow, it remained only to close the abdominal wound, with three stitches, the vesical incision, or rather incisions were left open. On the third day, while changing the dressing, an oval, oxalate stone, weighing one gram, was found sticking to the wound under the longest suture, and was easily extracted. Dr. Rüsanoff thinks the calculus had been ejected during the retching to bury itself somewhere in the antevesical cellular tissue. No suppuration occurred, the child making an excellent recovery. (2) A peasant boy, aged three years. The bladder was fixed by means of stout silk threads and then incised. An oval, oxalic calculus, weighing 3.68 grams, was extracted. The boy speedily recovered.—*Vratch*, No. 8, 1888; *Annals of Surgery*.

**EMPTYING THE BLADDER BY MANUAL COMPRESSION.**—Dr. Julius Heddaeus, of Idar, has found manual compression of the bladder an admirable substitute for catheterism in a considerable number of cases where mechanical aid of some kind is imperatively called for. He employs two methods, which may be used alternately, so as to give relief to the hands when they get tired. In the first method the surgeon stands by the side of the patient, who lies on his back. Looking toward the patient's face, he lays the right hand on the left, puts the thumbs together, and then grasps the bladder so that the thumbs lie close to the symphysis, pressure being made of course downward and backward, and the thumbs being gradually approximated to the little fingers. In the second method, the back is turned to the patient's face and the bladder grasped with the hands placed with their ulnar borders against Poupart's ligaments, the finger tips meeting over the pubes. In the first method the chief work falls on the thumbs, in the second on the fingers. The latter is especially applicable in cases where the bladder is only partly full. Manual compression must only be employed very lightly in cases where the bladder is overdistended, and where there is any inflammation or pain it is altogether contra-indicated. It is mainly useful where there is paralysis of the muscular coat of the bladder, whether with or without further paralytic affections. When

the sphincter is paralyzed, so that incontinence exists, this method may be employed for emptying the bladder after it has partially filled, so as to prevent the constant dribbling. One advantage of the manual method is that it may be safely taught to the patient's attendants in many cases, and thus the bladder may be emptied at stated times, and as frequently as the surgeon thinks requisite.—*London Lancet*.

**URETHRAL APPLICATIONS OF COPAIBA IN GONORRHEA.**—Dr. Martin Rively has tested the value of the direct application of copaiba in gonorrhea. His first case was that of a young man who, six days previously, had been exposed to contagion, and was now suffering from a thin yellowish discharge. A No. 23 steel bougie was smeared with balsam of copaiba and introduced as far as the membranous portion of the urethra, where it was allowed to remain for six to eight minutes. At noon of the same day, the scalding, on making water, had diminished, and on the following morning there was no trace of a discharge. The second morning the balsam-smeared bougie was again introduced; and a third application was made on the fourth day, although the patient considered himself cured. Four or five weeks afterward it was found that no symptom of gonorrhea had reappeared. Dr. Rively has tried the same plan of treatment since in eight cases of gonorrhea in the first stage, and obtained like results in all but one, where the circumstances were exceptional. In gleet he has obtained no beneficial results at all. In this direct method of treatment there is usually a slight burning sensation experienced immediately after the passage of the bougie, but this passes off in a few minutes. Of course, the ordinary restrictions on eating and drinking must be observed.—*Medical Register*.

**INFECTIOUS BRONCHO-PNEUMONIA IN MEASLES.**—Dr. Bard relates the story of a severe epidemic of measles in a village in the south of France, and traces in the official report of the medical officer some evidence that all, or nearly all, the fatal cases arose by infection from a single case, in which there was not only measles but also broncho-pneumonia. He is inclined to separate the infections of measles and broncho-pneumonia, and merely to admit that a state of measles renders a child much more liable to a separate infection of broncho-pneumonia. At any rate he is anxious to act on this hypothesis in isolation, and to keep apart two

classes of cases of measles, viz., those who have and those who have not what is generally termed the subsequent bronchitis. He points to some very high death-rates in measles, such as forty-two per cent during the years 1867-'72, and even sixty per cent in 1871, in the Hôpital des Enfants Assistés, at Paris, where all cases are put together. How far such startling figures may be due to want of ventilation and nutrition, he has no means of determining; but he advises not only ventilation, but also separation of the broncho-pneumonic cases so long as they are suffering in this way.—*London Practitioner*.

**SKIN DISEASES OF NERVOUS ORIGIN.**—In the course of his presidential address before the Neurological Society, Mr. Hutchinson gave the following three laws by which to recognize skin diseases owning an origin in some disorder of the nervous system. (1) The disease will not occur in round patches, nor in oval ones, nor in streaks, but will be arranged according to the branching distribution of the filaments themselves; it will be panniculate or corymbiform. This is a conclusive argument, in his opinion, against alopecia areata being of nervous origin. (2) There will be no power of infecting adjacent structures; the patches will not be serpiginous. Eczema, psoriasis, lupus, and many others tend to spread by extension; there is no such tendency in the case of herpes or scleroderma. (3) The diseases develop themselves fully in the first instance; the results, when once declared, do not increase. From the fact that when herpes zoster, if it occur a second time in a patient, never affects exactly the same area, Mr. Hutchinson draws the conclusion that the nerve is disorganized by the kind of neuritis which produces the original attack of zoster, and so is incapable of being involved a second time. Recurrent herpes is a different affection, for it leaves no scarring behind it, as does true zoster; moreover, it is curable by arsenic, while arsenic is capable of producing an attack of zoster.—*Illustrated Medical News*.

**CAMPHORATED NAPHTHOL.**—It has recently been found that naphthol, which is very insoluble in water, can be combined with camphor so as to form a liquid. It is only necessary to rub up one part of naphthol with two parts of dry camphor to obtain a creamy liquid. This product is of a pinkish color if the naphthol is not pure. It has been found to be an excellent antiseptic application to wounds and ulcers, and is said to clean off the false membrane in diphtheria.

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D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } - - - Editors.

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## CHLOROFORM IN DYSPESPSIA.

We copy from the Medical News several formulas, by different authorities, for giving chloroform in dyspepsia:

Chloroform administered in the various forms of dyspepsia overcomes fermentation and flatulence; it is best given in the following formulas:

1. Method of Dr. Wils: From ten to twenty drops of chloroform, to be taken in a few spoonfuls of sweetened water, in flatulent dyspepsia. After a few minutes eructations occur, followed by improvement.

2. Method of Dr. Huchard: Administer before each meal one dessertspoonful of the following:

Chloroform water.....150 parts;  
Mint water..... 30 "  
Water.....120 " M.

Or from eight to ten drops of the following mixture in a wineglass of water:

Tincture of nux vomica. }  
Tincture of gentian ..... } āā.... 3j;  
Tincture of anise..... }  
Chloroform .....gtt. xx-xl. M.

An appropriate diet and oxygenated waters at meal-times form part of this treatment.

3. Methods of Drs. Regnault and Lasèque: This treatment applies particularly to painful dyspepsias with dilatation of the stomach:

Chloroform water.....150 parts;  
Orange-flower water..... 50 "  
Water ..... 100 " M.

One dessertspoonful to be taken at intervals of fifteen minutes until the pain ceases.

Or the following for the same affections:

Chloroform water.....150 parts;  
Tincture of anise..... 5 "  
Water .....145 " M.

Chloroform has long been used internally in Louisville in the treatment of dyspepsia. It has been found useful also in vomiting both in Asiatic cholera and cholera morbus. But it is a drug to be used with some caution. Twenty drops of chloroform is a large dose, occasionally large enough to produce very unpleasant symptoms. The American Practitioner contained, now many years back, the report of a case wherein ten drops, taken in sweetened water, caused dizziness, faintness, and partial loss of consciousness, phenomena which persisted several minutes. This particular instance may, it is true, have been one of idiosyncrasy, for ten drops of chloroform would seem really not to be a great quantity to give at one time; yet it is well to have in mind the fact to which we here call attention.

## COTTON-SEED OIL PRODUCT.

It is a fact that the oil expressed from cotton seed when duly refined can scarcely be told from the best olive oil. Indeed it is said, by those who claim to know these things, that ship loads of crude cotton-seed oil are sent to the old world, where, after proper treatment, it is re-shipped to America as *huile d'olive*. Numerous attempts have recently been made to make of cotton-seed oil a perfect substitute for hog's lard. There is no reason why the pure oil should not be so used, except that the average cook has not yet been able to reconcile herself to the substitution of a liquid for a solid grease. A company has been recently formed in New York for the manufacture of an article which

does away with the difficulty. Cotton-seed oil is rendered of the consistency of hog's lard by mixing it with pure beef tallow.

We are indebted to the "COTTON OIL PRODUCT Co." for a sample of their ware, and are happy to say that its performances in the kitchen are certainly not inferior to those of the best country rendered hog's lard.

### ARMY MEDICAL RECRUITS.

Elsewhere in this issue will be found a notice of the organization of an Army Medical Board which will convene in New York City on the 1st of May. "There are at present seven vacancies in the Medical Corps, to which one more will be added in July by the retirement of a medical officer, making eight appointments which are to be recommended by this board."

This statement will doubtless be agreeable information to many an ambitious young doctor, since among the three or four score who expect to enter the contest there is none with so little faith in himself as to doubt his ability to secure at least the eighth place on the list. But the Board is merciless, and the contest will be hot; nevertheless we say, wade in, young man! If you secure a place it will be a proof of your superior attainments in [book] medicine. If you fail it will be no indication that you will not make of yourself a better doctor and a more brilliant success in life than he who goes into the service of Uncle Sam.

### Notes and Queries.

OBITUARY: DR. G. W. STRICKLER.—At the regular meeting of the Hardin County Medical Society, held March 7, 1889, the following preamble and resolutions were unanimously adopted:

*Whereas*, The death of our esteemed fellow member, Dr. Geo. W. Strickler, of Stephensburg, has been announced to this Society; therefore be it

*Resolved*, That in the decease of our brother and friend, this Society has lost one of its most prominent and able members, and the community one of its best citizens.

*Resolved*, That this Society as a body tender its heartfelt sympathy to the bereaved wife and family.

Dr. Strickler was born in Jefferson County, Va., in 1826; came to Kentucky when four years old, and was educated in Hardin and Nelson counties. He studied medicine with the late Dr. Smith, of Elizabethtown, and attended lectures and graduated at the Jefferson Medical College in 1850. He commenced practice in Nelson County, where he remained till 1861, when he enlisted in the Sixth Kentucky Infantry, of which regiment he was assistant surgeon. After the war he located at Stephensburg, Hardin County, where he continued until his death, February 20, 1889.

Dr. S. was possessed of more than ordinary ability, and had represented his county one session in the legislature. He was president of our Society last year.

*Resolved*, That the foregoing preamble, resolutions, etc., be published in the American Practitioner and News and the Elizabethtown News, with request that a copy of each publication be sent to the family of deceased.

Z. C. AUD,  
R. B. PUSEY,  
T. B. GREENLEY.

AN ARMY MEDICAL BOARD will be in session in New York City, New York, from May 1 to 31, 1889, for the examination of candidates for appointment in the Medical Corps of the United States Army, to fill existing vacancies.

Persons desiring to present themselves for examination by the Board will make application for the necessary invitation to the Secretary of War, before May 1, 1889, stating the place of birth, place and State of permanent residence, and inclosing certificates based on personal knowledge, from at least two persons of repute, as to American citizenship, character, and moral habits. Testimonials as to professional standing from professors of the Medical College from which the applicant graduated, and of service in hospital from the authorities thereof, are also desirable. The candidate must be between twenty-one and twenty-eight years

of age, and a graduate from a Regular Medical College, evidence of which, his diploma, must be submitted to the Board.

Further information regarding the examinations and their nature may be obtained by addressing the Surgeon-General United States Army, Washington, D. C.

JOHN MOORE,  
Surgeon General U. S. Army.

SURGEON-GENERAL'S OFFICE,  
Washington, D. C., April 1, 1889.

**DIPHTHERIA CAUSES MOST SICKNESS.—**  
A very valuable report on communicable diseases, compiled under the direction of the Secretary of the State Board of Health, has just been issued. It is deduced from the annual and special reports made by health officers, clerks, and presidents of local boards of health, physicians, and others. The work that has been accomplished during the past few years by the State Board of Health in suppressing outbreaks of communicable diseases is almost inestimable, and this department is constantly becoming more efficient. Whenever information is received at the office of the State Board of Health of the outbreak of diphtheria, scarlet fever, typhoid fever, smallpox, measles, whooping-cough, or glanders, a letter is sent to the health officer of the afflicted locality, calling attention to the existence of the disease within his territory; it indicates his power and also transmits documents of instruction with regard to prevention and restriction of the disease, for distribution among families especially exposed to it.

It is believed that these documents distributed in this manner are doing great good; for the neighbors of the sick are sufficiently alarmed to read the documents, and are thus led to co-operate in stamping out the disease.

The report shows that the communicable disease most prevalent during the year was diphtheria; and other contagious diseases in order were scarlet fever, typhoid fever, measles, smallpox, and typhus fever. In demonstrating the practical results of efforts at restricting diphtheria, it is shown that in 118 outbreaks in which isolation or disinfection,

or both, were neglected, there averaged 11.79 cases and 2.71 deaths per outbreak, while in 78 outbreaks in which isolation and disinfection were both enforced, there averaged only 2.54 cases and .65 deaths per outbreak, indicating a saving of 9.25 cases and 2.06 lives per outbreak.

Thus the local boards of health and officers who faithfully enforced restrictive measures have the satisfaction of knowing that their efforts have proved of solid advantage in preventing much sickness and many deaths.

The same result was attained with reference to scarlet fever and other contagious diseases. It appears from the report, that of the two diseases, diphtheria and scarlet fever combined, during the two years 1886, 1887, over 11,190 cases were prevented, and 1,685 lives saved in Michigan by isolation and disinfection. The pamphlet is replete with useful information, and will be found of great value to physicians and local boards of health, and through them to the people generally. These pamphlets can be obtained upon application to the Secretary of the State Board of Health.—*Lansing Daily Journal*.

**CHRONIC COCAINE-POISONING.—**M. Magnan has lately brought before the Société de Biologie, in Paris, an account of three cases of chronic cocaine-poisoning. The first was a business man, aged forty-eight, who had begun to treat himself with morphine for colic in 1878. In 1886 he stopped the morphine and took to hydrochlorate of cocaine, of which he soon came to take fifteen grains a day. After two months of this he began to have many and various hallucinations; he saw things moving round him, heard strange sounds which frightened him, and was in a state of abnormal excitability, his muscles often jumping and starting. He now gave up cocaine and resumed morphine, but only for six months, when he returned to cocaine. With the cocaine the hallucinations returned and he began to have sensations as of something under his skin. After a little while he had a well marked epilep-

tic attack. The second case was a druggist of forty-six, who, like the former, had taken morphine for colic in 1884 and turned to cocaine in 1887. He, too, fell into delusions of microbes under his skin, etc., and was shaky and trembling. In this case also an epileptic attack soon followed. The third case was that of a doctor, aged thirty-nine, who had taken morphine in 1872 for neuralgia, but had not suffered from the effects of it. In 1887 he took to cocaine, and soon reached the dose of thirty grains a day. Hallucinations of sight and hearing and strange sensations quickly followed. M. Magnan draws the conclusion that a chronic cocaine intoxication shows itself most clearly by hallucinations with a previous general disturbance of the senses. It is more like the action of alcohol or absinthe, and may be attributed to a similar action on the cerebral cortex, but an action slowly extending from the occipital region forward, and not in the reverse direction, as with alcohol and absinthe.—*Le Progrès Médical*.

CHARCOT'S OPINION OF PROFESSIONAL WOMEN.—M. Charcot, one of the Jury of the Faculty of Medicine in Paris, in complimenting a young lady who had obtained her doctor's degree, said that "women pass their examinations, when they do pass them, even more satisfactorily than men; but what will be always a bar to their success is that they have no real love of their proposed profession. What they aspire to is the first rank, the most prominent posts, the most lucrative offices; and what they dislike is the humble and unpleasant, but necessary, service of humanity, such as is given by the hospital dresser." Curious, but precisely the same thing might just as correctly be said of men. *Chemist and Druggist*.

OVERPRESSURE IN CHILDREN.—In a note recently published by Professor Charcot on "Overpressure," the author asserts that intellectual or cerebral overwork does not exist in children under sixteen years of age. A child, he says, can make only the amount of intellectual effort of which he is capable.

If he has programmes too overcharged to fulfill, he simply does not fulfill them; if one insists on cramming his memory with crude facts, no result whatever is obtained; but this does not in any way affect the brain of the child, the passiveness of which is complete, and the indifference absolute. On the other hand, according to the Professor, "overpressure manifests itself only in youths above sixteen or eighteen years. It is characterized by a number of nervous troubles, principally by a pain in the occipital region, which extends down to the back of the neck, and goes up again in front of the ears. This overpressure is seen in pupils of the superior branches of study, in men of letters who write much, in political men who are or who believe themselves to be overwhelmed with responsibilities, in men of business, etc., who lose their sleep, but never in the pupils of our lycées and colleges.—*Lancet*.

THE POLYPNEIC CENTER.—On a hot day, animals like the dog are seen to breathe very rapidly in order to keep themselves cool. To this state the name of polypnea has been given by Richet. In rabbits etherized, and with the cortex removed, Dr. Ott has found that removal of the corpus striatum and the parts between it and the optic thalamus abolishes the polypnea, although the external temperature is elevated. If the corpus striatum and the parts adjacent are electrically irritated at an ordinary temperature, the respirations are doubled or trebled in number. This discovery adds another proof that the basal heat-centers are the regulators of body temperature; for upon these heat-centers antipyrin acts to reduce temperature, and through the basal heat-centers septic poison produces fever.—*Philadelphia Medical News*.

BACTERIA IN MILK.—The Berlin correspondent of the *Lancet* says that it is intended to establish a bacteriological laboratory for the investigation of milk. The idea is due mainly to Dr. Hueppe, of Wiesbaden, who has for several years made a special study of the bacteria that appear in milk.

He has definitively proved that lactic-acid fermentation is caused by a special fungus, and butyric-acid fermentation by another. Prazmowski, Liborius, Fuchs, and Neelsen have discovered other bacteria in milk, and their purely scientific researches, undertaken solely with a view to widening the limits of bacteriology, are now bearing valuable practical fruit. It is known that infant mortality is due largely to unwholesome milk, which can now be rendered harmless by sterilization. Further practical advantages are certain sooner or later to accrue from these investigations.—*Medical and Surgical Reporter*.

*Editors American Practitioner and News:*

FRANKLIN COUNTY MEDICAL SOCIETY.—We send you this communication by order of the Franklin County Medical Society. We desire to have a State Medical Association organized on the representative plan, by having each county organize a medical society and electing one delegate for every ten or a fraction of ten members of the local county society. The delegates are to be the accredited delegates of each county society to the State Association to act for them. The State Medical Association is to be supported by an assessment of one dollar for each member of the county or local society, and in return each member of the local society is to receive a bound copy of the papers read at the State Medical Association. The State Association is to elect at its annual convocation or meeting delegates to the American Medical Association to represent the medical profession of the State of Kentucky.

We ask your hearty co-operation in this work.

G. F. THOMPSON, M. D.,

FRANKFORT, KY., April 8, 1889.

*Secretary.*

WEAK EYES.—A Knoxville, Tennessee, doctor advised a patient to use whisky on his forehead every morning for neuralgia. Meeting his wife a few days after, the physician inquired as to the husband's health. "He's no better," replied the lady. "But I told him to rub whisky on his forehead," said the doctor. "True," answered the lady, "but John never uses it higher than his mouth."—*Cincinnati Lancet-Clinic*.

A NATIVE INDIAN DOCTOR.—One of the recent graduates of the Woman's Medical College of Pennsylvania is a native Indian, Dr. Susan La Flesche, of whom Dr. Walker, in his address to the graduates, gave some interesting information. It seems that she commenced her studies of English at the school on the Indian reservation. Coming East, she continued them for a while at a boarding-school, and later at the Indian school at Hampton, Va., where she graduated in 1886, and then came at once to Philadelphia to study medicine. The impulse to a professional career was the result of a desire to see her people independent of the unskilled, and oftener indifferent, attention of the reservation doctor.—*Medical and Surgical Reporter*.

GERMAN STATISTICS.—The number of students in the medical faculties of the various German universities in the winter semester, 1888-'89, is given in the official lists as follows: Berlin, 1,456; Bonn, 317; Breslau, 388; Erlangen, 297; Freiburg, 309; Giessen, 122; Göttingen, 214; Greisswald, 405; Halle, 310; Heidelberg, 220; Jena, 213; Kiel, 219; Königsberg, 244; Leipzig, 840; Murburg, 209; Munich, 1,188; Rostock, 157; Strassburg, 306; Tübingen, 237; Würzburg, 984. The total number of medical students in the universities of the German empire is thus 8,635 as against 8,255 in the corresponding period of last year.—*Maryland Medical Journal*.

THE number of drugs in the German Pharmacopeia is only 606; in the Austrian, 560; in the Norwegian, 530. The United States Pharmacopeia contains 1,010; the English, 814; the Belgian and Spanish, about 1,500; while France leads the world with 2,000 drugs.

CONVENTION FOR THE REVISION AND PUBLICATION OF THE PHARMACOPEIA OF THE UNITED STATES.—A call for a General Convention for the revision and publication of the United States Pharmacopeia, to assemble in Washington, D. C., at noon of May 7, 1890, has been issued by Robert Amory, President of the Convention of 1880. It is requested

that every incorporated medical or pharmacal college, association, or society desiring to be represented in the Convention, send to Mr. Amory its corporate title and a list of its officers, addressed to the care of Dr. Edwin H. Brigham, Assistant Librarian of the Boston Medical Library, 19 Boylston Place, Boston Mass., in order that Mr. Amory may prepare for publication, as directed by the Convention of 1880, a list of the bodies to be represented.

THE International Congress of Hydrology and Climatology will hold its second session in Paris, from the 3d to the 10th of October. Papers and letters of inquiry should be addressed to Dr. F. de Ranse, 53 Avenue Montaigne, Paris, until June 1st, or Nériss (Allier) from June 1st until October 1st. Subscriptions, with a postal order for twenty francs, should be addressed to M. O. Doin, 8 Place de l'Odéon, Paris.

THE Lancet, February 23d, states that yellow fever is said to have broken out at Versailles, and to have numbered thus far four victims. It has been suspected that the germs of the disease have been carried there from South America in the plumage of parrots.

CANNABIN IN GRAVES' DISEASE.—Valieri, after using cannabin in three cases of exophthalmic goitre, recommends the following formulas:

Cannabin.....gr. ivss;  
Sugar of milk, q. s.....Mix.  
Make five pills.

S. To be taken in 24 hours.

Cannabin.....gr. ivss;  
Distilled water..... $\frac{3}{4}$  ij;  
Syrup of orange flowers.... $\frac{3}{4}$  j.

Mix. S. Take in teaspoonful doses in 24 hours.

Or we may prescribe a decoction of 2 or 4 100th parts, or doses of  $\mathcal{M}$  15 or 30 of the tincture.—*Wiener Med. Presse*, No. 41, 1888.

THE eighteenth Congress of the German Surgical Society will be held in Berlin, April 24th–27th.

DR. S. WEIR MITCHELL, of Philadelphia, has written a story of life in the lumber regions, which the Lippincotts will publish. Its title is, *Far in the Forest*. The work is said to be an outcome of personal observations among an interesting class of people.

MR. HENRY CARTER died recently in England at the age of ninety-two years. He is believed to have been at the time of his decease the oldest member of the Royal College of Surgeons of England. His death was caused by a fall which fractured his left hip.

THE twenty-seventh Annual Meeting of the Mississippi State Medical Association will be held in Jackson, Wednesday, April 17, 1889.

THE eleventh Annual Meeting of the Louisiana State Medical Society will be held in New Orleans, Tuesday, April 9, 1889.

A LABORATORY OF VEGETABLE PHYSIOLOGY is about to be established in connection with the Faculté des Sciences of Paris. Two and a half hectares of land in the Forest of Fontainebleau have been assigned by the French Government for the purpose.

DR. EDWARD T. BRUEN, of Philadelphia, Assistant Professor of Physical Diagnosis at the University of Pennsylvania, died March 31st, of pneumonia, after an illness of less than a week.

THE Alabama State Medical Association will meet in Mobile, Tuesday, April 9, 1889, and continue in session four days.

THE nineteenth Annual Meeting of the California State Medical Society will be held at San Francisco, April 17, 18, and 19, 1889.

THE thirty-ninth Annual Meeting of the Illinois State Medical Society will be held in Jacksonville, Tuesday, May 21, 1889.

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÂ."

VOL. VII.  
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No. 9.

*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.*

## Original Articles.

### TREATMENT OF IDIOPATHIC ANEURISMS BY COMPRESSION.\*

BY W. L. RODMAN, A. M., M. D.

*Demonstrator of Surgery, Medical Department University of Louisville.*

Compression as a means of treating aneurisms dates its beginning as far back as the close of the seventeenth century, when it was first practiced by Bourdelot. Soon afterward Guattani and others recorded cures by this method. The results, however, were very uncertain, on account of the unscientific way in which the pressure was applied. Compression was made directly over the sac, and considerably more force than necessary was used. Consequently, the dangers resulting from inflammation of and rupture of the sac were so conspicuous that the method fell into disuse, when John Hunter introduced the ligature as a means of treatment.

But compression of the main artery as a means of curing aneurisms naturally suggested itself after Hunter's discovery. In truth, he was perhaps the very first to try it. The real credit, however, of having given compression as a means of treating aneurisms a place in modern surgery belongs to the Dublin surgeons, Bellingham, Tufnell, Hutton, and Carté.

So generally is this conceded that all authors speak of it as the "Dublin Method." They practiced gradual instrumental com-

pression. In 1843 Bellingham published a treatise upon the treatment of aneurisms by compression, which showed him to possess an accurate and scientific knowledge of the subject. He clearly demonstrated the inutility of making such pressure as to cause complete arrest of circulation, adhesion of the sides of the artery at the point of pressure, etc., which had before this always been considered necessary. He it was who taught us that to cure an aneurism it was not necessary to entirely arrest the circulation through the sac, but to only diminish it. Compression as practiced by him cured aneurisms as nature does, viz., by the deposition of laminated clots.

The reintroduction of compression as a method of treating aneurisms by the Dublin surgeons, and the practical and sound teachings of one of their number, Bellingham, mark an era in surgery even more brilliant than the Hunterian operation. I say more brilliant, for the reason that I shall try to show that compression as a means of treatment is, when compared with the ligature, more generally applicable, can be used by a greater number of surgeons, is indisputably safer, and about as effectual.

Compression may be continuous or interrupted, digital or instrumental, and, as regards location, proximal, distal, or even upon the sac itself.

By continuous pressure we understand that an effort is to be made to cure the aneurism in one sitting, varying from one hour (even less) to twenty-four or longer.

By interrupted pressure we expect to cure in a more gradual way, spending several hours each day in the work, until the sac has become filled by laminated fibrin. This may require from three days to as

\*Read before the Louisville Surgical Society, April 7, 1889.

many months, though it is of very infrequent occurrence for an aneurism to resist this treatment more than two or three weeks.

Proximal compression has the same advantage over distal compression as proximal ligation has over distal ligation.

Compression made directly upon the sac is as a general rule not to be advised as an independent plan of treatment. But when cautiously made it is a good auxiliary to both the proximal and distal methods. It is the most desirable form of compression to make in rapidly spreading aneurisms which seem ready to burst. Here a cup-shaped pad of metal, accurately fitting over the aneurism, is to be used.

Which method of making compression is to be preferred, digital or instrumental? The situation of the tumor to a large extent decides this question. Aneurisms of the carotids, subclavian, and axillary can only be treated by digital compression, as it is impossible to use any form of tourniquet. The advocates of this method not only claim its availability in aneurisms of the above-named vessels, but in all cases where it can be used.

Statistics are certainly favorable to its use, Gross showing for it 104 cures in 138 cases, or 75.3 per cent. Only one death resulted, and this in a man seventy-one years of age with popliteal aneurism. It became solid in twenty-four hours. Gangrene set in, and the patient died two months afterward. 75.3 per cent of cures in 138 cases, with only one death, is indeed a favorable showing for digital compression. It is easy to understand the almost perfect safety of digital compression, it being due to the fact that the accompanying vein is not compressed to such an extent as to interfere with the free return of venous blood. Pressure is concentrated. When gangrene follows compression it is of the moist variety, and is due to pressure over the vein.

Instrumental compression, whether forced or gradual, gives us the best results to be had from any plan of treatment. All aneurisms, except those about the neck, fall within its domain. Gradual compression is

somewhat safer, but less likely to effect a cure.

Anesthesia is induced where pain is too great to be borne. Morphia does but little good. Chloroform and not ether is to be used, as the latter stimulates and excites the heart's action. Murray cured a large aneurism of the abdominal aorta by applying a tourniquet above the tumor. He first compressed the vessel two hours with apparently no benefit. Three days subsequently he again compressed it five hours, when all pulsation ceased in the tumor and none returned. *Six years* afterward the patient died suddenly. The *post-mortem* showed the aneurism for which Murray treated him entirely cured. He died from the rupture of a second aneurism some distance above the first.

Of 127 cases treated by instrumental compression 116 were cured, or 91 per cent. These cases were rigidly analyzed by Broca.

Gross says that not more than five or six cases have died from the effects of instrumental compression.

Holmes' statistics, while not so favorable as those of Broca, give 66 per cent of cures in a large number of cases. He adds, however, that in some of these cases the treatment was imperfectly carried out. He gives no mortality, and speaks as if there was no death in 124 cases.

The most recent method of treating aneurisms by compression is the one introduced in 1875 by Reid, of the English navy. It is only applicable to aneurisms of the extremities. It consists in applying Es-march's bandage from the distal extremity of the limbs firmly up to the sac, then passing lightly over the sac, and then firmly again for some distance above. In short, the limb is rendered bloodless. In twenty-nine successful cases the application varied from one half to three and a half hours. The pain caused by it is great, and should be controlled by light anesthesia.

Before removal of the bandage it is necessary to control the main artery by digital or instrumental compression. This should

be continued for about six hours, to prevent the clot being broken up and washed away. Coagulation of the blood *en masse*, and not *in laminae* as in gradual compression, is the result of this treatment. This treatment has been used in nearly a hundred published cases, and, eliminating those where it is acknowledged that it was imperfectly carried out, 85 per cent were successful. Two deaths are recorded. The one reported by Dr. Weir would probably have died anyway, as gangrene was impending. 68 per cent of the successful cases yielded to one application, 17 per cent to two, and 15 per cent to three. It is discouraging if the first application fail. The advantages of this treatment are that it requires such a short time, and that it is successful in 85 per cent of all cases. The dangers incident to it are, (1) That gangrene, due to rupture of small vessels, may occur. (2) Rupture of the sac may result. This happened in one case. It can best be prevented by controlling the artery leading to the sac. It is not likely to occur unless the aneurism be so situated that the bandage can not be carried above the sac, and dependence is placed upon a tourniquet to make proximal compression. Here the tourniquet may slip on account of some movement by the patient, and, as blood enters the sac from above and can not escape below, it may become distended until it ruptures. (3) In the upper extremity paralysis may follow its prolonged use.

Having now considered the individual methods of making compression, we will speak of the treatment in a general way. It is unquestionably entitled to the first consideration of the surgeon in any case of surgical aneurism. No author that I have read ranks it second to any other treatment. Bryant, Holmes, Erichsen, Druitt, and Gross give it the first place, and condemn ligation as a primary treatment. The beauty of compression is, that in one form or another it will cure nearly all aneurisms: failing to cure, it lessens the danger of ligation by establishing the collateral circulation.

When contrasted with ligation by the

Hunterian methods, which all admit to be the best, the result is highly flattering to compression. It cures as many cases, is practically free from danger (not causing a greater mortality than 1 per cent, if so much), and, failing, leaves the case in as good if not a better condition for other plans of treatment.

The mortality after Hunter's operation is frightful, and I am sure is not generally appreciated from its great popularity. I will here give the tables of Norris and Stephen Smith, which account for all published cases up to within a few years past. They report 579 cases which gave a mortality of 198 cases, or 33.1 per cent. Of the individual arteries there were—

	CASES.	DEATHS.	PER CT.
Subclavian.....	69	33	47.8
Carotid.....	149	54	36.2
Femoral.....	204	50	24.5
External iliac.....	118	33	27.9
Internal iliac.....	7	3	42.8
Common iliac.....	32	25	78.1

These statistics can be made still more appalling by including ligations of the aorta and arteria innominata, which is not done. With the light of these statistics before us, can any one doubt that it is the duty of the surgeon to first give compression a fair trial before even thinking of the knife?

The advocates of the ligature will say, "But these statistics were made very largely before the antiseptic era." That is true, and I am willing to admit that the dangers from both secondary hemorrhage and septicemia will be almost done away with under the new method of treating wounds. It will be found, however, that after making this deduction the mortality is not markedly changed. The one great danger after ligation is gangrene, and this will not be lessened by antiseptic measures.

I have the notes of five cases of ligation of the femoral artery. Four were made for popliteal aneurism, three in Scarpa's triangle, one in Hunter's canal. All of these were done under strict antiseptic precautions. Three were cured; one died from gangrene, necessitating amputation high up the thigh. Here we have a mortality of

25 per cent, which is 0.5 per cent above the mortality in the tables of Norris and Smith. The fifth case was operated upon before antiseptis, during my stay in Jefferson Hospital. The femoral was tied in Scarpa's triangle for aneurism of the posterior tibial. Ordinary silk was used as a ligature, and left hanging out of the wound. Secondary hemorrhage and suppuration of sac led to an amputation of thigh to save life. He recovered after having pyemia and every thing else a man could have.

After reviewing the statistics of ligation and compression I am forced to one of two conclusions: either surgeons in general do not appreciate the enormous fatality after ligation, or that they discredit the virtues of compression. Otherwise, how explain the fact that men go along doing an operation which statistics show is wholly unjustifiable except in the rarest instances.

LOUISVILLE.

### TETANUS AND TETANY.\*

BY D. T. SMITH, M. D.

*Lecturer on Medical Jurisprudence, Medical Department University of Louisville.*

Like typhus and typhoid fever, tetanus and tetany were, from the earliest ages to a comparatively recent date, regarded as a single disease. As they are different in their cause, their prognosis and treatment, it is obviously of the greatest importance that they should be readily distinguished from one another.

Tetanus is a disease of the nervous system, characterized by persistent tonic spasms with violent brief exacerbations. These spasms, with rare exceptions, commence in the muscles of the neck and jaw, and involve the muscles of the trunk more than those of the limbs. The disease is fatal in a large proportion of cases. Usually the result of a wound, it sometimes occurs without apparent external injury, and especially after exposure to cold. It is also met with in new-born children, and occasionally results from childbirth or abortion. Always acute

in the outset, it is likewise always chronic in those that recover.

As regards its etiology it is found that, excepting the instances where it occurs in newly-born children, males are about six times as liable to the disease as females; a difference due doubtless to the increased exposure on the part of males. It seldom occurs under five years of age. Dark-skinned races suffer more than white under equal exposure, and in hot countries the disease is more common than in temperate ones; but in temperate climates its occurrence does not appear to be influenced by weather or by season of the year.

The immediate causes of tetanus are, chiefly, two, injuries and exposure to cold. It is liable to follow wounds of every character and degree, from the most trivial to the most severe, from the prick of a pin to ovariectomy. But it is far more common after punctured, contused, and lacerated wounds than after incised ones; hence its rarity in surgical operations. Injuries of the nerves have been supposed to be a prolific cause, especially injuries of the smaller nerves distributed to the hands, feet, and legs.

Tetanus usually appears from five to fourteen days after the receipt of the wound causing it, but many cases have been recorded as coming on in forty-eight hours, while in a few cases it has come on immediately. Again, it may commence during the third or fourth week, seldom later than a month.

Idiopathic tetanus is usually excited by exposure to cold, especially wet cold, when the body is perspiring. Cold is doubtless the determining cause also in many cases that come on after the receipt of a wound; to this circumstance probably can be attributed the greater frequency of tetanus among those who are wounded in battle.

Puerperal tetanus, perhaps the most terrible form of the disease, is frequent in hot countries, though even there it is in a large proportion of the cases the result of some abnormal condition.

Tetanus neonatorum, somewhat rare in temperate climates, is exceedingly common

\* Read before the Medico-Chirurgical Society, March 29, 1889.

in certain tropical countries, and in some far northern localities. It is supposed to be caused by an arteritis extending from the umbilical wound to the cord. It is more than doubtful if the wound of the cord has any share in its production, but as this lesion must be always present in the new-born, it is not easy, if possible, to produce negative testimony. Whatever the cause, the symptoms as a rule are the same. Vague pains in the epigastrium, the head, and in traumatic cases at the seat of the wound, have in occasional instances preceded the onset. It begins with stiffness, appearing first in the neck and jaw, involving also the tongue; it then passes down, embracing the spinal muscles and the legs. The facial muscles soon become involved in rigidity, the eyebrows being drawn up by the frontalis, while the ocular fissures are lessened by the orbicularis. The angles of the mouth are drawn down and outward, and the upper lip is pressed against the teeth, giving rise to what has been termed the *risus sardonicus*.

At a very variable time paroxysms of spasm come on, strongest in the muscles which are the seat of the rigidity; and all the appearances due to the rigidity are exaggerated during the attacks. Severe cramp-like pains are now felt in all the contracted muscles, and pain is especially severe in the epigastric region. From the violence of the muscular action and the severity of the pain the body is covered with sweat, and during the paroxysms the perspiration may pour in streams from the body. Opisthotonic spasm is the rule, but the body may be bent in any direction. The tonic spasm is occasionally intermittent, though usually constant. Occasionally it is so short and rapid as to resemble a slow clonic spasm. The spasm usually ceases during sleep, to return again with undiminished force when the patient awakes.

The temperature varies. Often normal through the whole course of the disease, or rising only a couple of degrees toward the end, in some cases the temperature may rise before death to 110°, and even 114°.

In one form of tetanus known as cephalic tetanus, and usually arising from wounds of the forehead, there is, in addition to the other symptoms, paralysis of the face on the same side as the injury. Every one of these cases hitherto recorded has been fatal where the patient was above twenty-five years of age.

The duration of the disease, in cases that recover, varies from two or three days to five or six weeks, or even two months. As first pointed out by Dr. D. W. Yandell, in a contribution to the literature of this disease which has become classic, when it begins within ten days after the receipt of the injury recoveries are extremely rare, though recoveries are on record where the disease came on within three days. Hippocrates seems to have had some notion of this kind in mind when he speaks of the great fatality of *recent tetanus*, an expression which can best be explained by referring the recency to the injury. Gowers points out that Dr. Yandell made the error of basing his percentage of recoveries on cases separately published, and most likely published because they were recoveries. As the unreported cases were, however, nearly all fatal ones, the deduction he derived from his statistics are not vitiated.

Pathological anatomy reveals nothing more than may be found in persons who have died from other convulsive diseases, making due allowance for the length of time the body is exposed to the spasmodic muscular action.

In well marked cases the diagnosis presents no difficulties, but milder cases, and some cases in their earlier stages, are not so easily distinguished. In the onset simple rheumatism may resemble it. Trismus, nearly always present in tetanus and never in simple rheumatism, should awake suspicion. From post-hemiplegic spasms it is to be distinguished by the absence of paralysis elsewhere. Symptoms of strychnine poisoning, to which it bears some resemblance, never begin with trismus, though the first spasm may occur in the jaws. In strychnine poisoning there is no pain in the epigastrium.

while it is great in tetanus. Exaggerated spasms in hydrophobia are much more likely to lead to mistake, but the early history of the two diseases and the initial symptoms will prevent error.

Trismus, causing persistent closure of the jaws, is common in hysteria; but tetanoid spasm is extremely rare in hysteria except as part of a convulsive attack, and then its nature is sufficiently conspicuous. Usually the absence of rigidity in the neck and the suddenness of the onset, with other symptoms of hysteria, will rarely leave any doubt as to its nature.

To give the treatment that has from time to time been tried, is to give the index of the *materia-medica*; and while individual cases seem to have been cured by particular remedies, we have yet to await a satisfactory showing of the influence of medicine on the disease.

*Tetany.* I have said that tetany and tetanus were for a long time, indeed till the time of Trousseau, almost indistinguished. And even now students who repair to the country as soon as they leave school and engage in the exacting task of country practice, unable to study up the distinctions, may still be led into reporting cases of tetany for tetanus.

Tetany is rather more frequent in males than females, and most frequent in infancy and in the second decade of life. A direct exciting cause of tetany is traceable in at least three fourths of all cases. Diarrhea, lactation, and exposure to cold while the system is below par are, in the order named, the most frequent exciting causes.

Anemia, alcoholism, and sexual excesses are other occasional causes. In young children indications of rickets are nearly constant. In Europe it has been found to occur with singular frequency after excision of the thyroid. It comes on during or after many forms of acute disease. Epidemics of tetany have been met with on the Continent, especially in schools and prisons; and it has been notably prevalent in outbreaks of typhoid.

*Symptoms.* The peculiar symptoms in the

limbs come on, as a rule, without premonitory nervous disturbance, but they are occasionally preceded by headache, pain in the back, *malaise*, and even vomiting not due to gastric derangement. Usually the muscular disturbance is preceded for a few hours or days by a sense of tingling or burning in the extremities. The spasm most always sets in suddenly in the hands and feet at the same time, rarely in the hands only, and still more rarely in the trunk. The hands at first feeling stiff and cramped, soon become fixed. The fingers are usually flexed at the metacarpo-phalangeal joint and extended at the others; the thumb is adducted and in contact with the index finger, or flexed beneath it; the palm is hollowed, and the fingers may be bent either to the ulnar or radial side. Sometimes the fist is closed; the wrist is slightly flexed, and the elbow free. The feet are extended at the ankle-joint, and are inverted in the position of talipes equino-varus. The toes are strongly flexed, the knees usually extended, and the thighs sometimes adducted.

In severe cases the muscles of the trunk and head share the spasm. The abdominal muscles become rigid, and spasmodic retention of urine may occur. Occasionally there is a slight degree of opisthotonos, though the muscles of the back are usually unaffected. The thorax may be fixed by spasm, which may even involve the diaphragm, causing difficulty of breathing, cyanosis, and even unconsciousness. The angles of the mouth may be drawn out and the eyelids half closed, the jaws at the same time being closed by spasm of the masseters. There may be strabismus, either convergent or divergent.

The muscles become hard under the tonic spasm, and pain usually results from attempts to extend them. Slight contractures are not painful, but when there is considerable spasm severe cramp-like pain is experienced in the muscles.

The spasm is usually paroxysmal, and after continuing for a time, which may vary from a few minutes to a few hours, and in rare instances to a few days, the contracture

gradually passes off again, recurring often at variable intervals of hours or days. Occasionally a continuous spasm may occur, and end in death.

Unlike tetanus, the spasms may continue during sleep, and even come on in that state, or yet more, even be restricted to it—nocturnal tetany.

In the intervals the nerves are excitable and the muscles irritable, when spasm may be produced by pressure on a nerve or a tap on a muscle.

During severe spasms there is often copious perspiration. Sometimes local vaso-motor disturbance produces redness and even slight edema. The pulse is quickened, but the temperature is scarcely changed, seldom rising above 101°.

Three varieties of the disease are distinguished, intermittent, remittent, and continuous, but there is every gradation between these varieties. In nearly all cases the spasm is symmetrical, though one-sided cases have been met with.

The disease varies much in its duration. The more continuous its character the shorter may be expected its duration. The disease may last only a few days, but often it lasts for months, and one case is on record, coming on after excision of the thyroid, which lasted for three years.

Most cases of tetany end in recovery. When death has occurred it has been usually attributable to the cause of the tetany. In a few instances the spasms have been the direct cause of death.

No *post-mortem* changes have been found which can be regarded as the cause of the disease, such as have been observed being probably due to functional overaction.

In making out the diagnosis the greatest weight is to be given to the peculiar and almost pathognomonic character of the spasm, its commencement in the extremities and its bilateral symmetry, which as a rule sufficiently indicate the nature of the disease.

The intermissions in the spasm, the increased excitability of the nerves, and the excitation of the spasm by their compres-

sion corroborate the diagnosis when they are present, but they are often absent.

The disease is distinguished from tetanus by the intermitting character which the spasm commonly presents, by the peculiar posture of the hands, and by the fact that spasm of the masseters, the earliest symptom in tetanus, is the latest in tetany. In organic brain contracture there is paralysis; in tetany this never occurs. Hysterical contracture may closely resemble tetany, but hysterical contracture is nearly always unilateral, while tetany never is.

Treatment is to be directed to removal of the cause when this can be ascertained. Bromides, digitalis, Calabar bean, and chloral have been mainly relied on in the disease in conjunction with the treatment of the cause.

LOUISVILLE.

### EXTERNAL MEANS IN THE DIAGNOSIS OF PREGNANCY.

BY E. S. M'KEE, M. D.

Among the many changes of fashion, some for better, some for worse, which pervade the medical world, is a tendency to depend more and more on the external methods of diagnosing the pregnant state. This is a good thing, and deserves cultivation, for it is a question of more importance and practicability than many which are occupying so much attention from the profession.

This great country of ours is behind in this respect, and it is in the immense hospitals of Dublin, Germany, and of France, where we find this art is best taught and practiced. The *tactus eruditus* is as capable of cultivation in this direction as any other, and will yield its cultivator as rich a harvest. Experience here, as elsewhere, is an excellent teacher.

"He who does not examine a woman does not infect her" is a maxim of Credo. In his recent work this authority teaches that woman in labor and in the lying-in state is diseased only through infection from fresh wounds. Solutions of continuity are always, or nearly always, connected with

childbirth. The most serious of these are generally made from some artificial assistance to parturition; yet from the most careful digital examination we may have some wounds, and therefore should limit them to the fewest number possible or dispense with them altogether. We may in many cases be safe in doing this when we understand the external means better. The digital examination is omitted altogether for weeks together in the lying-in hospital at Leipsic, especially if the health of those confined is not the best, and the results are the most favorable. In labor the external examination should be given precedence, and the internal employed only when demanded by the conditions of the case, for the surest prophylaxis from infection lies in the total abstinence from vaginal examination. But we must learn exactly the position of the child and the stage of labor. To accomplish this we must use wisely and scientifically all the external means for diagnosis.

Inspection, from the natural order of things, is one of the first methods at our command. In the face we are often able to see a peculiar brownish pigmentation called *la masque* or *chloasm*. The breasts reveal the pigmented areola or the tubercles of Montgomery. The size of the abdomen and the brown line extending down the center are to be noted. The umbilical cicatrix, depressed, obliterated, or protruding, shows to some degree the stage of pregnancy. A transverse and distinct furrow has been pointed out by Bandl; it lies about midway between the umbilicus and the pubis. This occurs when an abnormal obstacle presents itself to the child's expulsion. The *linea albæ* of recent date are of a livid blue or rosy red, while old ones are white, and resemble old cicatrices. Movements of the abdominal wall from activity of the fetus are often noticed, also the uterus projecting through between the borders of the recti muscles when the patient lies in bed. The stage of pregnancy can often be determined by the height of the uterus with reference to the umbilicus, though many conditions may detract from the value of this symp-

tom. In a multipara the breasts are flaccid and pendulous, and the nipple enlarged and withered. The abdominal walls are flabby, often look withered and discolored, and can easily be raised into folds, and sometimes the skin is pendulous and pouch-like over the pubes. This aids to dispel these signs.

Palpation of the abdomen in pregnancy not only proves the presence of the fetus *in utero*, but the number of feti. This method was first practiced by Mercurius Scipio in 1601. In palpating a woman we should be careful to use the greatest possible gentleness, as force frustrates the object by causing the woman to be afraid of you and to render the muscles of her abdomen hard and tense. The examination should not be superficial, but systematic, scientific, and accurate manipulation. By it you are able in most cases to ascertain the existence of pregnancy, the position *in utero*, approximate size, general conditions of the fetus, and the relations of the uterus. We are enabled by the information thus gained in many cases to readily rectify malposition, to facilitate expulsion of the placenta, to prevent or arrest *post-partum* hemorrhage. Abnormalities in form and texture of the upper part of the uterus and its appendages and the abdomen can be detected. To palpate properly the thighs should be flexed partly on the abdomen with about twenty inches between them, the rectum and bladder empty, and the decubitus as horizontal as possible. Lay one hand, warm, on the hypogastrium of the patient so as to become accustomed to the contractions of the muscle. In a very short time this disappears and we can freely explore and outline the uterus. If the muscles are still too firm, we can gain time by talking to the patient, thus taking her attention from herself and gaining relaxation. We can get the size of the uterus by plunging the hand deeply into the region of the fundus and grasping this part between the hand. By making alternating pressure we can displace the solid body and thus produce *ballotement*. If the shock of this movement occurs of itself it is termed fetal movement; these movements are also

sometimes present by auscultation. We can determine the presentation and position. The head, we find a round, hard body, partially displaceable, more or less perceptibly separated from the trunk by a depression—the neck. I have not met with the parchment-like crackling sensation found under favorable circumstances by firm pressure on the head. The nates also form a hard, round, and movable mass, but the distinctness of these characteristics is less marked than in the head. In the normal position of the fetus the feet are a smaller and more prominent part. They may be displaced from their position in the liquor amnii, and may be displaced with the utmost facility by one hand. They do not return with that quick rebound which, in the case of the head, gives the sensation of *ballotement*. The heel or sharp malleolus can be felt sometimes if the abdominal walls are thin and the conditions for palpation favorable. The back is found between the head and the breech, and, the fetus being curved on itself, the back is more prominent on the one side than on the other. The back furnishes a more firm resistance than the front, and on the front we find movable parts. If the abdominal walls are thick and the amniotic fluid abundant, and it is difficult to decide the points of diagnosis, it is a good plan to seize the fundus of the uterus in the hand and force it down against the symphysis pubis, and thus bring the back more in the range of palpation. When the head is flexed, as it must necessarily be for engagement, there must be a depression of the occipital protuberance on the one side and an elevation of the forehead on the other. The side which offers the least resistance will correspond to the occiput, and the other to the forehead. This gives us the direction of the back, which will be on the side opposite the forehead. Failing to find the head in the superior strait we must look elsewhere. It may be far away; it may be in one of the iliac fossæ. In the latter case we have only to slide the hands a little to one side. If above the umbilicus, we find it in much the same way, and distinguish it by its round-

ness, resistance, and mobility, which prevent our mistaking it for any thing else. The absence of the furrow or depression of the neck is an item of importance in searching for the breech. The anterior shoulder, if palpable, is reliable evidence, as it is always situated in the same lateral half of the pelvis as the occiput. The head engaged, it forms a prominence over the superior strait, lying on the left side in the first position and on the right in the second.

Abdominal *ballotement* may be made with one or both hands. It is one of the most reliable symptoms of pregnancy, yet it has been found in a woman having a multilocular ovarian tumor. It can only be obtained at the fourth month, and is especially useful at the sixth and seventh months. Hydramnion and multiple pregnancy prevent its detection. The books describe it as the sensation of a piece of ice floating in a vessel of water and striking against the sides. The placenta can sometimes be detected by palpation when it is placed anteriorly. It is recognized as a fleshy mass which raises the palpating fingers from the fetal surface.

The death of the fetus can often, though not always be, determined by palpation. The hand finds a peculiar flabby and compressed condition of the abdomen contrasting sharply with its former firm and elastic feel, and motion is not distinguishable. The body remains passive in any position it may be pushed. By means of the calipers we can measure the fetus, applying them to the head and to the breech. This gives one half the length of the fetus, thus giving the age of the fetus and the size of the uterus. The cord has been made out, passing over the back. In the diagnosis of twin pregnancies by palpation we find two absolutely identical parts as heads; three large parts may be made out, or two separated so much as to make it impossible for them to belong to the same fetus.

Intermittent uterine contraction, first brought to our notice by Braxton Hicks, is almost infallibly peculiar to the pregnant uterus. It is constant, not simulated by any other sign, and one of the most valuable means of obstetrical diagnosis. It

occurs every five to ten minutes, and is present whether the fetus be alive or dead. The detection of abdominal tumors, uterine fibroids, and ovarian cysts is quite possible by palpation during pregnancy, and this detection is of the greatest importance.

Fetal movements may be sensible or visible. We can not always rely on the statements of the mothers, and it is necessary that we appreciate these ourselves. If there is sufficient amniotic fluid to allow a free movement, the fetal movements are free and active. If too much liquor amnii is present, they are rapid and flighty. As a rule the size of the fetus and the amount of the liquor amnii are in inverse proportions.

Extra uterine fetation can be detected only when a distinct lateral tumor is palpable, quite disconnected from the uterus. Palpation ought to be practiced after auscultation, because manipulation disturbs the mother and child, increases the heart-beat, and modifies the results gained by auscultation.

Percussion is of the least value of the means of external diagnosis. The amount of distension of the bladder is the most important of the things learned. Light percussion sometimes produces a tympanitic sound if the intestines get in front of the uterus. By using more force, however, we can bring out the dull sound of the pregnant uterus. It has been claimed that pregnancy can be made out in the second month by percussion, but this is hardly possible.

Auscultation is one of the most important of the means of diagnosis made externally, but is too often relied on to the exclusion of other means. Other methods afford valuable information, and the examination, to be accurate, valuable, and thorough, should include all four. The first advocate was Mayer, of Lusanne; the first pupil, Keraradec. Dopaul enlarged its scope, and after some opposition it spread through Germany, France, and England. The stethoscope in use should be of medium length and cover considerable surface. It should be held perpendicular and kept in position by the head of the examiner, avoiding all contact with the hand

or the clothing. It is useful, but by no means indispensable. It is claimed that the point of maximum intensity can be more accurately ascertained by this instrument than by the ear unaided; but with practice the ear becomes wonderfully proficient in this respect. For myself I prefer the ear in most cases. The stethoscope is probably better to get at the uterus when just above the superior strait. Auscultation enables us to hear the umbilical or funic murmur, the placental murmur, the pulsations of the abdominal aorta, and the gurgling noises caused by the fluids and air in the intestines. Occasionally there may be heard a splashing noise due to the movements of the fetus in the liquor amnii, the fetal shock, muscular subsultus, sounds due to the friction of the uterus against the abdominal walls, others by the impact of the fetal limbs against the uterine walls, and, the most important of all, the fetal heart. When plainly heard, this proves to us not only the presence of the fetus, but also the fact that it is healthy and strong. We can with reasonable assurance say, when we fail to find the fetal heart, having always found it before, that the child is dead.

Twin and triple pregnancies can often be diagnosed by auscultation. In twin pregnancies there are two points of maximum intensity, then a point of minimum intensity, which should augment as we approach the respective points where the heart is plainest heard. The two hearts must have a different rhythm. If the sounds do not emanate from the same heart, they are plainly audible at several different points, and at intervening points they are not audible, or scarcely so.

The fetal heart is first heard at the eighteenth to the twentieth week. It is reported heard as early as the twelfth to the fourteenth week, but such cases are rare. The auscultator should be careful not to listen with the head lower than the body, for he thus causes an increase of the cerebral circulation and hinders hearing. Schroeder's statement that the fetal heart can always be made out in a healthy mother and child

is rather too strong. With a moderate amount of practice the fetal heart can be heard in almost every instance. The frequency is from 120 to 160 per minute. It increases on fetal activity and with the temperature of the mother. If the maternal temperature rises to  $102^{\circ}$  the fetal pulsation is much accelerated, and if above  $104^{\circ}$  the fetus usually dies. There seems to be no definite relation between the frequency of the maternal heart-beat and the fetal. The intensity of the fetal pulsation varies with the fetal development, the thickness of the abdominal walls, the quantity of the amniotic fluid, and the position of the fetus. If the maternal pulsation is much accelerated, the difference of intensity serves to differentiate between the two.

The diagnosis of the sex of the child by the fetal heart-beat was a subject which at first gave much promise. Investigation, that destroyer of new theories, proved disastrous. The number of pulsations per minute will come nearer determining the weight of the child than its sex. We can doubtless say that the majority of cases, wherein the pulsations are less than 130 per minute, will be males, and the majority of those where the pulsations exceed 130 will prove females. This comes from the fact that males are larger and heavier in general than females, and the pulsations in larger animals are less frequent than in smaller ones. It has also been found that the pulsations in the males are fewer per pound than in the females. The pulse has been found to vary as much as 15 to 20 beats in consecutive minutes in the latter months of pregnancy. Increased size, hardness, and firmness of the crania of males, as compared to females, probably offer more chance of determining the sex than the number of pulsations, but here also exceptions are numerous.

The uterine souffle is not a certain sign of pregnancy but one of considerable probability. It is sometimes palpable in the form of a distinct thrill in the immediate vicinity of the umbilicus. The umbilical souffle is also a sign heard by auscultation.

Presentation and position are diagnosed

by auscultation. Depaul says that the heart is situated nearer the head than the breech. Matthews, Duncan, and Ribemont deny that there is any difference. The low position of the heart in cephalic presentations is probably due to the engagement of the head and subsequent sinking of the trunk. In pelvic presentations the breech does not become engaged, and the heart is more readily found engaged high in the uterus. Chastrenod and Tarnier also disbelieve in the difference in the heart beat in the cephalic and pelvic presentations. In face presentations we have the heart sounds transmitted through the cardiac region of the fetus, the maximum of intensity being at the right, directly opposite to where it should be in head presentations. The head failing to engage, the heart sounds will be heard higher in the uterine cavity. The disagreement between auscultation and palpation will probably call the attention of the examiner to the possibility of a face presentation. In the diagnosis of transverse positions auscultation is much inferior to palpation. It may be stated in a general way that in the cardinal positions the maximum of the heart sounds will correspond to one of the four segments which is made by drawing a line from the ensiform cartilage to the symphysis pubis intersected by a line which divides the uterus into two equal parts. This line should not be drawn through the umbilicus, for this is a most migratory organ.

Knowledge of the presentation and position of the child before labor has advanced too far may enable the accoucheur to change a transverse or breech position, or make a normal out of an abnormal labor.

The advantages gained by a use of the external means in the diagnosis of pregnancy are numerous and valuable, and he who does not avail himself of them lays himself subject to censure.

CINCINNATI, OHIO.

THE Kentucky State Medical Society will meet in Richmond, May 31st, 2nd, and 10th.

## Societies.

### LOUISVILLE SURGICAL SOCIETY.

Stated Meeting April 8, 1889, D. W. Yandell, M. D., President, in the chair.

#### CONTINUED REPORTS OF OLD CASES.

Dr. W. O. Roberts: The patient with papiloma of the bladder, upon whom, four weeks ago, I did an epicystotomy, is doing well. The wound in the abdominal and bladder walls is not yet healed. Urine still escapes through it, and of course delays the process of repair.

#### REPORTS OF CASES.

CASE 1. Dr. Roberts: A negro, aged thirty years, employed on the N. N. and M. V. Railroad, fell from a bridge a distance of twenty-five feet, striking his shoulder. He suffered no fracture or dislocation, but so injured the posterior cord of the brachial plexus as to produce slight paralysis of the triceps and complete paralysis with atrophy of the deltoid. The accident happened eight weeks ago. The speaker had never seen so complete a paralysis with so much atrophy following an injury after so short a time. The case was referred to Dr. H. A. Cottell for electrical treatment.

#### DISCUSSION.

Dr. Ap Morgan Vance: I would suggest, by way of treatment in this case, suspension of the arm to retard the tendency to waste, and the daily application of faradism.

Dr. W. L. Rodman: The case (which I saw by the kindness of Dr. Roberts) appeared to me to be one of traumatic neuritis. I would advise in treatment iodide of potassium and electricity.

Dr. A. M. Cartledge: In my experience time is the most potent curative agent in these cases. I believe massage to be just as good as electricity in their treatment. If such cases do not show marked improvement in the space of two months, they will probably never recover.

Dr. D. W. Yandell: I have seen but two cases of complete paralysis due to trauma. The muscles regained their power, but not until after three months of treatment.

CASE 2. Dr. Roberts: A woman, aged fifty-four, consulted me for stone in the bladder. She says she has passed one hundred and eighty calculi in two years. She has been confined to her bed since last October. There is almost constant dribbling of the urine. Putting the patient under chloroform, I dilated the urethra and removed nine stones. The dilatation was accomplished in less than two minutes.

#### DISCUSSION.

Dr. Yandell had dilated the urethra widely and without difficulty in a girl of thirteen years, from whom he removed a large calculus.

Dr. Turner Anderson: Dilatation of the female urethra may be made to an almost unlimited extent if the surrounding condensed areolar tissue be first excised. He had found this to offer considerable resistance. He had dilated the urethra and explored the bladder without anesthesia in the University clinic. The operation is not devoid of danger.

Dr. I. N. Bloom: In Dr. Roberts' case incontinence of urine justified, if it did not facilitate the operation. There is danger in these cases of permanent incontinence. It is better to cut through the anterior vaginal wall, remove the stone and close the wound.

Dr. Vance had seen a stone as large as a duck's egg removed *per urethram* by Dr. John Goodman. The procedure was not followed by incontinence of urine.

Dr. Yandell admitted the danger of incontinence following dilatation of the urethra, but had not encountered the complication in five cases wherein he had removed the stone by this method. Once, in a girl three years of age, he dilated with a pair of dressing forceps, and, hooking his finger around it, removed a stone the size of a large chestnut. The caliber of the dilated urethra was sufficient to admit the passage of the stone and finger at once. No incontinence followed. In his last case the patient made water voluntarily in four hours after the removal of the stone. Incontinence in these cases is, I think, something of a bugbear.

Dr. Roberts: Incontinence, it is claimed, follows slow rather than rapid dilatation.

The essay of the evening was read by Dr. W. L. Rodman; subject, The Treatment of Idiopathic Aneurisms by Compression. (See page 257.)

#### DISCUSSION.

Dr. Roberts had had little experience in the treatment of aneurism by compression. Had seen four cases not his own. Of these, one was cured by means of the Esmarch bandage. The danger of this method is gangrene induced by stoppage of the capillary vessels. In none of the cases he has seen was digital compression followed by cure of the aneurism. He thinks that failure by compression lessens the chances of cure by the ligature, the collateral arteries being unduly enlarged by compression of the main vessel. Hemorrhage and septicæmia, the dangers formerly urged against treatment by ligature, are now, since the introduction of animal ligatures, almost *nil*. I see no reason, anatomical or mechanical, why treatment by the ligature should be more likely to be followed by gangrene than treatment by compression.

Dr. Yandell does not agree with Dr. Roberts as to the dangers relatively of the two methods of treatment in aneurism. Digital compression is not usually fraught with danger, and under any circumstances, if the disturbance of collateral circulation should be great, the surgeon can at once remove the pressure. If treatment by ligature has any advantage over compression, it would seem to be in the facility with which it is done. To cut down upon the vessel and to tie it is a brilliant surgical procedure, and soon accomplished. To treat by compression is very slow and tedious. The temptation to the surgeon to do the former in every case, I admit, is very great; but there are many cases in which duty will force him to take the slower route. He believes that compression, so far from enhancing the dangers of gangrene, will lessen it by slowly dilating the anastomosing arteries and thus insuring collateral circulation. If he feared gan-

grene as a result in a given case, he would, prior to ligating the vessel, practice compression until he had produced complete dilatation of the collateral vessels. The speaker referred to five cases of popliteal aneurism, in three of which he had practiced compression, and in two had used the ligature. They were all cured. It is expedient first to try compression, I believe, in most cases. It is hard to get enough pressure without an anæsthetic, and difficult to make the pressure with the patient under chloroform. Digital compression is always to be preferred to instrumental, of course.

E. R. PALMER, M. D.

GLYCERINE IN OZENA.—In a communication published in *Der Miltbeard*, Dr. Sello mentions the great benefit obtained in a case of ozæna of the most repulsive kind by treating it locally by means of injections and applications of glycerine. The patient had suffered from an affection of the nose some two years previously, which had been followed by the complete loss of the sense of smell, and by repeated attacks of epistaxis. Upon examination, the cavities of the nostrils were found to be filled with foul scabs. Daily syringing with a two-per-cent solution of chloride of potash, with ten per cent of glycerine, was ordered, and cotton-wool soaked in a twenty five per cent solution of glycerine in water was introduced once or twice a day and allowed to remain for an hour. Under this treatment not only did the foul odor rapidly disappear, but the patient regained his sense of smell.—*London Lancet*.

N. GAMALEIA ON ETIOLOGY OF CHICKEN CHOLERA.—Gamalein's researches prove that the bacillus of chicken cholera is constantly present in the intestinal canal of pigeons without producing pathological results, in this respect resembling *Pasturella dysenteriae* occurring in the intestines of mammals. Gamaleia proposes to name the former *bacillus aviculus*. It becomes more virulent after passing through a rabbit.—*Kienbergk Med. Journal*.

## Reviews and Bibliography.

**Bright's Disease of the Kidney.** By ALFRED L. LOOMIS, M.D. 117 pp. Detroit, Michigan: George S. Davis. 1888.

This is a contribution to the excellent series of monographs, *The Physician's Leisure Library*. The name of Professor Loomis, as author, is sufficient guarantee that the subject is properly treated.

The vexed question of the actual poison producing the eclamptic symptoms of Bright's disease is discussed with ability, but with the usual unsatisfactory results, and the philosophy of cardio-vascular changes receives the share of attention so interesting a subject is entitled to.

Particular interest attaches to this part of the subject for the writer, on account of some supposed original contributions of his own to its elucidation.

On page 30 Dr. Loomis tells us that "in 1868 Dr. George Johnston stated that the thickening of the walls in the brain, muscles, and tissues generally, which is found in connection with Bright's disease, is due to the hypertrophy of the muscular coat," and that "Dr. Johnston's own explanation, that the hypertrophy is due to an attempt on the part of the system to shut off from the tissues blood which is deleterious by reason of being surcharged with excrementitious products, seems untenable." It is to the writer rather a source of regret to have to give up to Dr. Johnston his claims to priority in these views, but he takes pleasure nevertheless in contending that they are probably correct views.

There is no more proper stimulant for the heart than healthy blood, and there seems a peculiar relation of harmony between the blood and the *intima* of the arteries. As long as healthy blood passes to the tissues the arteries are stimulated by it merely to a healthy tonic action, but whenever the blood departs from the normal the arteries, by a kind of unconscious intelligence, contract so as to keep such blood from reaching the tissues. As, however, the tissues present a stronger claim on the centers govern-

ing nutrition than do the arterioles, these centers compel the heart by overexertion to force blood through the resisting arterioles to the famishing tissues. The watch-dogs at the gate are overcome by messengers sent to deliver food to the starving inmates of the house. This may result in hypertrophy of the muscular coat, as it certainly does in increased blood-tension and hypertrophy of the heart.

In some respects these changes are produced by pregnancy, by any form of hydremia, by constipation where the blood absorbs injurious matters, and in all cases, perhaps, where the blood departs from the normal. This is the writer's theory, which he is quite willing to pass to the credit of Dr. Johnston on the ground of priority, though not of originality. D. T. S.

**A Hand-book of Therapeutics.** By SYDNEY RINGER, M.D., Professor of the Principles and Practice of Medicine in University College. Twelfth edition. 524 pp. New York: William Wood & Co. 1889.

To announce a twelfth edition of any work is to proclaim its favor with the public, and when to this is added that the author is Dr. Sydney Ringer the reviewer has fairly performed his task.

The reader who seeks tests and demonstrations of the physiological action of drugs, and philosophy of that action so far as yet made out, will find greater satisfaction in the work of Brunton than in this. But nowhere will he find a fairer and clearer discussion of drugs with reference to the indications for their use in disease.

The author, while never unduly skeptical, is yet not one of those who gives medicine by faith and counts the results by permutation, who finds each drug good for nearly every disease, and none without a remedy.

Unfortunately for therapeutics, it is rarely that we know what would be the exact course of disease in any given example, and thus it is well-nigh impossible to know exactly what our medicine has accomplished.

A further misfortune still is, that the science is heavily burdened with the art. The

interest of experimenters biases all in the same direction. It profits us to claim all the triumphs and to shift all failures to the shoulders of nature. Year by year, however, the certain methods of physical science invade the precincts of medicine, and they promise some time in the future to bring method and certainty out of chaos and confusion.

The twelve editions of Sydney Ringer's work have helped much in this direction, but it can as yet by no means be said that nothing more remains to be done. D. T. S.

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**Hand-book of Materia Medica, Pharmacy, and Therapeutics.** Compiled for the Use of Students Preparing for Examination. By CUTHBERT BOWEN, M.D., B.A. 366 pp. Price, \$1.40. Philadelphia and London: F. A. Davis, Publisher. 1888.

This hand-book aims at furnishing candidates for examination in our medical schools with a *résumé* of those points in materia medica, pharmacy, and therapeutics with which they should be familiar in order to meet the requirements of graduation in any reputable institution. It is written in the form of question and answer, which is undoubtedly best for the purpose had in view, as it very often happens that, while a student is master of the knowledge required for a proper answer, he is surprised into failure by not having such knowledge formulated into the shape of an answer. Nor should we be surprised if many an examiner, as well as student, might find in its pages a good measure of aid in his tasks.

D. T. S.

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**The Functions and Disorders of the Reproductive Organs in Childhood, Youth, Adult Age, and Advanced Life.** By WILLIAM ACTON, M. R. C. S. Seventh edition; 263 pp. Price, \$2.00. Philadelphia: P. Blakiston, Son & Co. 1888.

For many years Acton on the Reproductive Organs has been regarded as a standard work. We know of no recent author who has engaged in the study of the subject with greater love for his task and greater effi-

ciency in its treatment in the line the author has chosen.

When the author first began the discussion of the functions and disorders of the reproductive organs, the field was in a large measure in the possession of quacks; now, however, largely as the result of his labors, legitimate and able practitioners permit themselves to be known as willing to bestow as much consideration on the aberrations of the generative functions as on those of any other. It was to be hoped that this most desirable consummation would result in putting a stoppage to the unspeakably base system of plunder conducted by charlatans under the mask of "medical advice." Those who indulged such hopes, however, have hitherto been disappointed. We need yet more. First, we need that the government impose the same penalties upon those who use the mails for the purposes of quackery that it imposes upon their brother thieves and counterfeiters; and, in the second place, there is need of a plain common sense literature that can go into every family and teach the laws of sexual health. For such instruction this work, though well suited for the physician, is not at all adapted.

D. T. S.

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**Surgical Bacteriology.** By Nicholas Senn, M. D., Ph. D., Professor of Principles of Surgery and Surgical Pathology, Rush Medical College, Chicago, Ill. 8vo, pp. 270; cloth. Price, \$1.75. Philadelphia: Lea Brothers & Co. 1889.

**A Hand-book of Therapeutics.** By Sydney Ringer, M. D., Professor of the Principles and Practice of Medicine in University College, Physician to University College Hospital, London. Twelfth edition. 8vo, pp. 524. New York: William Wood & Co. 1889.

**Report on Medical Education, Medical Colleges, and the Regulation of the Practice of Medicine in the United States and Canada, 1765-1889.** By John H. Rauch, M. D., Secretary Illinois State Board of Health. 8vo, pp. 163. Springfield: H. W. Rokker. 1889.

**Lectures on Nervous Diseases from the Standpoint of Cerebral and Spinal Localization, and the Later Methods Employed in the Diagnosis and Treatment of these Affections.** By Ambrose L. Ranney, A. M., M. D., Pro-

fessor of the Anatomy and Physiology of the Nervous System in the New York Post-graduate Medical School and Hospital, etc. Profusely illustrated with original diagrams and sketches in color by the author, carefully selected wood-cuts, and reproduced photographs of typical cases. 8vo, pp. 778; cloth. Philadelphia: F. A. Davis. 1888.

Kirkes' Hand-book of Physiology. By Morrant Baker, F. R. C. S., Surgeon to St. Bartholomew's Hospital, late lecturer on Physiology at St. Bartholomew's Hospital, etc., and Vincent D. Harris, M. D., London, Demonstrator of Physiology at St. Bartholomew's Hospital. Twelfth edition, rearranged, revised, and rewritten. Five hundred illustrations. 8vo, pp. 784; cloth. New York: William Wood & Co. 1889.

The International Medical Annual and Practitioner's Index. A reference work for medical practitioners. New York: E. B. Treat & Co. This work is the seventh edition of the English "Medical Annual." It is a *resume* in dictionary form of the New Remedies and New Treatment that have come to the knowledge of the Medical Profession throughout the world during 1888. The volume includes articles or departments edited by Sir Morell Mackenzie, M. D. (Laryngology), London; Jonathan Hutchinson, jr., M. D. (Genito-Urinary Diseases), London; J. W. Taylor, M. D. (Gynecology), Birmingham; William Lang, M. D. (Ophthalmologist), London; James R. Leaming, M. D. (Heart and Lung), New York; Charles L. Dana, M. D. (Neurologist), New York; H. D. Chapin, M. D. (Pediatrics), New York, and others, comprising a list of twenty-three collaborators widely known in Europe and America. In its enlarged and widened sphere it takes the name of "The International Medical Annual." It is published in one octavo volume of about 600 pages, at \$2.75, under copyright protection, and is issued simultaneously in London and New York.

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## Correspondence.

### LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Dr. Richardson has been engaged on some curious and, as it would seem, completely successful experiments in turning the graphophone to account for medical purposes. The experiments were divided under the heads of "pulse-reading" and "cough-reading." As re-

gards pulse-reading, Dr. Richardson has succeeded in taking impressions on the wax cylinders of several varieties of pulse—intermittent, irregular, full, quick, slow—and the respective qualities of each are easily heard. By a more simple process, however, it is found practicable to produce a record readable by the eye on paper which may be transmitted by post. From recording the pulse on the wax cylinder he moved on to the recording of coughs and coughing sounds. In this case Dr. Richardson considers the results were exceedingly definite and practical. The cough had simply to be taken, and the return cough by the graphophone proved as clearly distinct as the original. On one cylinder four varieties of coughs were taken. In listening to these it was difficult to divest the mind of the belief that it was not the patient who was producing the effect by his own present efforts. As regards the practical value of these novel applications, Dr. Richardson observes that to be able to compare a cough of to-day with a cough of a month or a year ago, would be a good clinical observation, and may be so immediately available to the consulting-room that he has determined to bring it into practice. For lecture purposes he thinks it would be obviously useful. The sum total of the experiments is, that any sound whatever indicative of health or disease, and any animal motion of health or disease that admits of being translated into sound, can now be recorded, made permanent, and reproduced any number of times either for comparison, demonstration, or observation.

Beta-naphthol has recently been administered in three one-fourth-grain doses, repeated every two hours, to some patients suffering with typhoid fever. The results obtained appear to have been, almost without exception, extremely satisfactory—this internally applied antiseptic reducing the temperature, rendering the breath, skin, and excreta comparatively sweet, and, generally speaking, lessening fetor and otherwise promoting recovery. Even the period of the disease seems to have been shortened in those instances where the drug was given, as compared with others where it was not used. Only in two cases, some gastric irritation occurring, it was found expedient to alter the

treatment, and in each instance a relapse took place on the intermission of the beta-naphthol. The alpha modification, which is now said by some inquirers to be less liable to cause irritation of the mucous membrane of sensitive patients, does not appear to have been tried.

The fourth annual report of the National Association for Supplying Female Medical Aid to the Women of India carries forward the story of the Countess of Dufferin's narrative of "three years' work," and shows really marvellous progress. Branches are now established in all parts of India, and the Association can now boast of twelve female hospitals and fifteen dispensaries, including the magnificent institution in Bombay known as the Cama Hospital. At the hospital of the branch in Burmah there were treated last year two hundred and twenty-eight cases, of which one hundred and one were obstetrical, and that of these one hundred and ten represented paying patients. So far are the prejudices of race and custom from standing in the way, as was anticipated, native women appear to be everywhere availing themselves eagerly of the medical assistance offered to them. Most of the patients admitted to the newly established Burmah Hospital were brought thither in a critical condition, owing to the ignorant treatment of native midwives. It has been determined that in future the task of selecting ladies in England for employment under the Association will be undertaken by a committee consisting of persons who have resided in India, but the field is so great that women practitioners must ultimately be obtained from India. Great progress has already been made in this direction. There are now more than two hundred and twenty female students in the various medical schools and colleges, and the number is rapidly increasing. At the half-yearly examination at Hyderabad two of the lady competitors beat the whole of the male students and secured the first places in their class.

For the past ten years or more Mr. William Webster has been experimenting upon sewage purification by means of electricity. The sewage is discharged by a pump from a main sewer into shoots fitted with the iron plates or electrodes, which constitute the feature of his

system. These plates produce by an electric current, and in a few moments of time, that which is brought about by a more tedious action of precipitating and oxidizing chemicals. At the positive pole chlorine and oxygen are liberated in a nascent state, so that the organic matter in the sewage is rapidly oxidized and burned up to innocuous compounds, while at the negative pole ammonia, potash, soda, magnesia, etc., are obtained. The sewage thus treated is run into settling tanks. At first the precipitate rises to the top, but it gradually sinks to the bottom and a clear effluent remains on the surface. The only question is, whether Mr. Webster's plan is more economical than the use of chemicals. In large towns where the rain is mixed with the sewage the cost is higher, for the more solid the sewage the larger the proportion of salts and the less power required for precipitation. Mr. Webster estimates that a twenty-seven horse-power dynamo is capable of treating one million gallons of sewage, and £4 per horse-power would probably be the cost of the initial plant.

In cases of poisoning by cocaine, the inutilty of making a quantitative analysis has just been demonstrated. Traces of the poison were found in the blood, lungs, and heart, but not in any other organ. Quantitative analysis is declared to be impossible four days after death.

In the course of a lecture on Inebriate Criminal Responsibility to the Society for the Study of Inebriety, the president, Dr. Norman Kerr, arraigned the present treatment of drunkards and criminals as simply confirming them in their evil habits. There were ten thousand commitments for drunkenness of females in Glasgow, forty per cent of the women having from eleven to eight hundred convictions against them. The average sentence of seven days simply enabled the fifteen hundred individuals to recover from a drunken fit and set them up again for a fresh drink.

Professor I. S. Burdon Sanderson has been appointed president of the Section of Biology at the forthcoming meeting of the British Association at Newcastle-on-Tyne. The first general meeting will be held on Wednesday, September 11th.

Dr. Barlow has recently had under his care a case of subclavian aneurism which has been cured by careful dieting and a long course of iodide of potassium. There was a history of syphilis. Five-grain doses of the iodide were used at first, subsequently increased to fifteen.

Iodol has, in the hands of some, been found preferable to iodide of potassium in cases of chronic bronchitis and other chronic pulmonary affections. It is in such cases becoming somewhat extensively used.

LONDON, March, 1889.

### PARIS LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Various experiments having been performed with certain cardiac medicaments, the following results have been attained with three of the principal, viz., digitaline, strophanthin, and sparteine. In some cases, which are rare, where a strong impulse is necessary to excite the functions of the heart, strophanthin will be employed with success. Sparteine is the stimulant *par excellence* of the contraction of the heart, only it does not modify the arterial pressure. But neither the one nor the other of these medicaments will surpass digitaline, which acts distinctly, although very moderately, on the sanguineous pressure, while at the same time it regulates the contractions of the heart. The recent works of Dr. Laborde, the eminent physiologist, give support to this assertion.

In 1884 Dr. Galezowski, the well-known ophthalmologist, proposed to combat ataxic papillary atrophies by subcutaneous injections of the cyanide of gold and of potassium. The results obtained encouraged him to persevere in this method; but the solution employed by Dr. Galezowski being attended with certain inconveniencies, Dr. Roussel, who has specially devoted himself to what he terms hypodermic medicine, proposes to substitute for Dr. Galezowski's solution the following formula: Cyanide of gold and of sodium, ten centigrams; saturated camphor-water, ten grams. According to this, half a syringeful corresponds with five milligrams, and the syringe entire with one centigram.

The advantage of the camphorated water over ordinary water is, that it permits the solution to be preserved a longer time without being altered, without becoming irritating, and without losing its action. Dr. Roussel always recommends that these injections should be practiced with long needles, in order that the medicamentous liquid should be pushed as far as possible under the skin. One advantage of Dr. Roussel's formula over that of Dr. Galezowski is, the salts of sodium, being more soluble, are more easily injectable than those of potassium; but the cyanide of mercury is a product far superior, and Dr. Roussel states, in his *Journal of Hypodermic Medicine*, that he has for some time employed it with the greatest success against all the phenomena of ataxy.

It is known that for some time doubts have been entertained as to the antiseptic properties of iodoform. Moreover, iodoform has the inconvenience of being disagreeable and difficult to support, owing to its peculiar odor. In seeking to remedy these defects, R. Yaksch remarked, in an article reproduced in *Les Nouveaux Remèdes*, that all the antiseptics of a specific odor possess the property of completely masking that of iodoform; at the same time their own odor becomes scarcely perceptible. The following antiseptics may therefore be employed as deodorants and disinfectants of iodoform, thymol, naphthaline, tar, creoline, etc. It is preferable to employ for this purpose creoline itself. Iodoform creolinized, containing from one to two per cent of creoline, presents, well triturated, a powder of a light brown color, a faint aromatic odor, and is soluble in alcohol and in ether. The water dissolves the creoline, but leaves the iodoform undissolved. For some time the author employed the creolinized iodoform for the treatment of wounds, abscesses, etc., in the form of powder or of gauze. The results were not inferior to those obtained by iodoform alone; on the contrary, this preparation seemed to diminish more the secretions and to stimulate the granulations.

Apropos of creoline, I may here note that

in a communication to the Central Society of Medicine of the North on this new antiseptic Dr. Lemoine stated he had obtained good results in an obstinate case of ozena and in two cases of catarrhal sore throat, in solution of seven drops to one liter of salted water. In certain ulcerated tumors, cancer at the neck of the womb, adenoma of the breast, creoline at two per cent removed the fetid odor; less results were obtained in carbuncle.

The intensity of the painful reaction consecutive to the injection of the tincture of iodine into the tunica vaginalis, to obtain the radical cure of hydrocele, varies according to the individual. Some do not suffer, while in others the pain is so severe that syncope is the result. We have in chloroform a general anesthetic to suppress the pain, but it has some inconveniences, so that surgeons are obliged to have recourse to local anesthesia.

Dr. Ricard writes, that for this purpose an injection of a solution of cocaine into the tunica vaginalis, after having evacuated the liquid, will be found useful. Fifty, forty, or thirty centigrams of cocaine dissolved in equal parts of water, according to the size of the hydrocele, is injected. The solution is left in contact with the tunica vaginalis for seven or eight minutes; it is then drawn off by the trocar, and this is followed by an injection of the tincture of iodine. During the operation the patient does not suffer for about an hour, but at the end of this time pains in the kidneys and along the spermatic cord are felt, which last from one to two hours. Commenting on this note, Dr. Fano, in the *Journal d'Oculistique*, writes that, from what precedes, it results that the injection of a solution of cocaine into the tunica vaginalis prior to the injection of the tincture of iodine only retards the explosion of the pain caused by the contact of the liquid with the serous membrane of the testicle. This, he says, is a poor advantage in comparison with the grave accidents which might occur after the absorption of from thirty to fifty centigrams of cocaine. After having given an account of the dangers at-

tending the indiscriminate use of cocaine, Dr. Fano relates that the experiments conducted by Biggs show that cocaine exercises a depressing action on the heart; that the force and frequency of the pulsations of this organ are diminished; that, later on, the heart is paralyzed. This would explain the production of the cerebral anemia, characterized by the paleness and the retraction of the blood-vessels of the optic papilla, as may be seen with the ophthalmoscope.

Dr. Witherie vaunts the use of the sulphuret of calcium in the treatment of phthisis. He prescribes it in pills containing three centigrams of the salt, commencing with one pill every two hours, and even oftener, until the medication gives rise to eructations or other disagreeable manifestations. Usually one succeeds in getting the patients to support two pills an hour. A distinct improvement has been obtained in all the patients submitted to this treatment, which, according to the author, must have for immediate effect to cause to pass into the blood sulphureted hydrogen in efficacious but inoffensive doses.

According to a note reproduced in the *Courrier Medical*, Dr. Nussbaum affirms to have rapidly cured erysipelas with an ointment composed of iethyol in equal parts with lanoline, covered over with salicylated cotton wadding. The day after the application all the morbid symptoms were ameliorated, and on the third day had entirely disappeared.

PARIS, April 12, 1889.

#### LETTER FROM CINCINNATI.

Dr. F. J. Thornbury, of Cincinnati, formerly of Syracuse, N. Y., a graduate of the Medical College, has been appointed as one of the resident physicians to the Cincinnati Hospital.

Mrs. Mary J. Pulte, widow of the late Dr. Pulte, died recently, and left of her ample means numerous charitable bequests, among which was five thousand dollars to the Ohio Hospital for Women and Children, situated in this city.

The Cincinnati Hospital has just issued its twenty-eighth annual report. The whole number of patients admitted to the different departments numbered 4,125, of whom 375 died, showing a mortality of 7.8 per cent. The mortality last year was 8.7 per cent, which shows a decrease of 1.1 per cent. The classification of cases was done according to the nomenclature adopted by the Royal College of Physicians of London. The mortality in 161 cases of typhoid fever was 8 per cent. Deducting complications, the mortality is reduced to 6 per cent. The mortality in the different departments is as follows: Medical, 112—9 per cent; surgical, 3.9 per cent; obstetrical, 2 per cent; gynecological, 4 per cent. The clinical and pathological school of the hospital, which now forms a department of the University, numbered three hundred and fifty-two students. The school for nurses connected with the hospital promises to do a good work. 224 women were delivered in the hospital, of which 133 were unmarried; 151 were primiparæ and 73 multiparæ. There were 2 cases of puerperal peritonitis, 8 cases of puerperal septicemia, 1 case of puerperal pyemia, 1 case of puerperal eclampsia, 1 case of puerperal mania. Presentations: Vertex, 208; breech, 10; shoulder, 3; arm, 1; footling, 2. There were 16 cases of abortion. The hospital library is in a prosperous condition. The number of volumes is 5,618; number of pamphlets, 1,058; number of photographs, 159. 587 bound volumes and 309 pamphlets have been added during the past year. The steady growth of the library and its ever-increasing value to the medical profession is becoming more and more apparent. Much praise is due the librarian, Dr. William Carson, and the custodian, Mr. P. Alfred Marchand, for their earnest efforts on behalf of the library.

The trustees of the Journal of the American Medical Association will please give attention to the fact that Cincinnati has many men who know, or think they know, how to run a medical journal. True, many of these are unknown in the field of medical literature, yet this does not detract

from their idea as to how the thing should be done. They are not at all backward about their criticisms of a local medical man's work in this line, although he has been for thirteen years actively engaged in journalism. This, however, does not give an idea of their ability, for they take it on themselves to criticise matter, editorial and otherwise, published by the editors of the Medical Register, the Philadelphia Medical Times, the Indiana Medical Journal, the Cincinnati Medical Journal, and the American Lancet. Think of that elegant gentleman, the erudite editor of the American Lancet, President of the American Academy of Medicine, which is nothing if not high-toned, being told what he should and what he should not admit in the columns of his journal! By all means, have the trustees come to Cincinnati. The only danger is that they will not be able to choose from the specimens presented.

Dr. C. D. Palmer has returned from an extensive trip on the Pacific Coast, and resumed practice at the old stand.

Dr. L. C. Carr has been presented with an elegant silver cup by the citizens of Jacksonville for his heroic services there during the last yellow-fever epidemic.

The gentleman who was before the Committee on Ethics at the Academy of Medicine recently was exonerated by that committee.

Dr. David DeBeck has been elected Librarian to the Cincinnati Academy of Medicine, and has undertaken the duty of establishing a library. Donations will be thankfully received.

The disinfection of surgical instruments was a subject very well handled at the Academy by Dr. Leonard Freeman. He had made microscopical examinations of various surgical instruments in use about the city, and his discoveries were astounding. He thought it unwise to pin our faith either to carbolic acid or to corrosive sublimate in the sterilization of our instruments, but to common boiling water or its equivalent steam at 100° C. A point of great importance, he thought, was that in-

struments should have smooth and continuous surfaces. There should be no cracks or screw-heads where it is possible to avoid them. He had examined the scrapings from the nails of a surgeon both before and after washing his hands. Strange to say, he found more bacteria after than before the ablution. This was probably because the water loosened the material beneath the nails and made it more easy to remove.

Deafness from syphilitic disease of the labyrinth was the subject of a report to the Cincinnati Medical Society by Dr. Joseph Eichberg. The patient, a young lady, presented an interesting history. She lived with a married sister. Her brother-in-law became syphilized, and gave it to his wife. The young lady was away on a visit, and on her return kissed her brother-in-law before he could prevent her. He had been warned of the danger in this, and was much shocked in due time to see a syphilitic eruption break out on his sister-in-law.

E. S. M'KEE, M. D.

### Abstracts and Selections.

THE TREATMENT OF LOCOMOTOR ATAXY BY SUSPENSION. — *Ignotum per ignotius*. This maxim applies to most, if not all, therapeutic agencies, but to some in much greater degree than others. The new method of treatment of locomotor ataxy now advocated by Charcot and his disciples is an illustration of this maxim. But we do not on that account ignore it, only it is necessary, with so powerful a means for good or evil, to try it with caution and test it with skeptical judgment. In estimating the good or evil effects of treatment, it is most necessary to have regard to the natural history of the disease. Many individuals are under the impression that, once the diagnosis of locomotor ataxy has been pronounced by a competent authority, there must be an end to all hope. This view is entirely erroneous. Physicians of experience can quote cases of stationary *tabes dorsalis* by the score, and stationary at any period of the disease from its first dawn to its last flicker. Cases are known in which there was positive recession of the disease, and even considerable improvement, if not prac-

tical recovery, either with or without treatment. On the other hand, cases may steadily descend from bad to worse, but a slow and steady progression is by no means the rule; long intervals of slowly progressive impairment may be broken by short, sharp shocks of sudden deterioration; indeed, the variety of the clinical history of these cases is as complicated as the imagination could picture. The fact that *tabes dorsalis* may grow suddenly worse is of importance in considering the value of the suspension treatment, because at least one case has been referred to as having been made worse by the treatment. It can not be too strongly urged that the utmost care is necessary in commencing the treatment, and it is possible that suspension without the aid of the armpit straps is too violent a measure at any period in the treatment of the disease.

At the invitation of Dr. de Watteville, we had an opportunity of examining one of the cases under his care at St. Mary's Hospital, the said patient having been under treatment by suspension for six weeks, being, we are informed, the first patient in England on whom the new means of treatment has been tried. In regard to this case, no doubt of the nature of the affection can exist, though whether the disease is due to a condition of the nerves or more central fibers in the cord and brain can not be decided. The patient is a man aged thirty-nine, married, and a carpenter by trade. He is said to have had rheumatic fever ten years ago, and at times since; but questioning the patient left it doubtful whether these symptoms were not of spinal origin, and therefore signs of the disease from which the man still suffers. In 1877 the patient remembers to have first noticed something wrong with his legs, and on the Christmas of that year he caught a severe cold which laid him up all through the summer of 1878. In 1879 he suffered from vomiting and diarrhea, began to see double, and the legs became worse; then shooting pains made life miserable, bladder troubles set in, and the disease steadily advanced. At the present time the man is somewhat anxious-looking and very thin. He could not stand at all with his eyes shut, but he can now, although unsteadily. He was very much more steady both in walking and working at his trade than he had been previously to the commencement of the treatment by suspension. He had not been able to walk at all without the aid of two sticks for several months before January this year, but he recently walked three miles and a half without expe-

riencing a sensation of fatigue. The improvement in the gait has been slowly going on during the treatment. Another important amendment has been the almost entire disappearance of the lightning pains. Since the treatment has been begun there have been nocturnal erections of the penis, which had not been the case for years. These erections partake of the nature of "spermatic crises," so characteristic of spinal cord disease. Charcot has noted them in his series of cases treated by suspension. That this patient has been benefited by the treatment neither Dr. de Watteville nor others, who have followed the case throughout, have any doubt. The man himself also feels much improved by it. Suspension has been practiced for from thirty to fifty seconds twice a week, axillary straps being always used. Dr. de Watteville is of opinion that suspension by the head alone should never be practiced until the other mode has been frequently practiced first.

In conclusion, we may say that in the present early stage of the trial of the remedy it is obvious that caution must be exercised in forming an opinion of its efficacy.—*London Lancet*.

**TREATMENT OF TABES DORSALIS BY SUSPENSION.**—The idea of treating cases of locomotor ataxy by hanging the patients up in a suspender, as if they were going to have a Sayre's jacket put on them, originated with Dr. Motchoukowsky, of Odessa, who reported in 1883 that he had found considerable improvement resulting from the method in the twelve cases in which he had tried it. He had at first suspended his patients for half a minute at a time, and gradually increased the time of suspension to three minutes. This was done once a day, the arms being held up during suspension to increase the traction on the spinal column. The same treatment had been carried out by Professor Charcot on eighteen cases of locomotor ataxy, giving a sum total of about four hundred suspensions. Out of these eighteen patients it was practiced on four not more than three times, chiefly from the difficulty of bringing the patients to the hospital, and so the number on whom satisfactory trial was made may be reduced to fourteen. Out of these fourteen there was very marked improvement in eight. They were cases in whom there could be no doubt as to diagnosis; most of them were in regular attendance at the Salpêtrière for treatment by cauterization along the spinal column. The first sign of improvement produced was

almost always in the gait. As a rule there was no change after the first few trials; then for two or three hours after the suspension the patients felt their walking-power less incoordinate and more comfortable; and after eight or ten trials the improvement became permanent, and it was not difficult for them to walk about in the crowded traffic of the streets of Paris. Improvement in the control of the bladder follows, and there are longer intervals between the lightning pains. As the treatment has only been carried on for three months, it is too soon to judge of all that it may bring about. In two cases the soles of the feet regained sensation; there was some improvement in the others. There was one exception in the case of a man of thirty-two, in whom all the symptoms of tabes had come on and reached almost their climax in six months. While under suspension treatment there was at first slight improvement, then a severe attack of lightning pains, and a loss of power in the upper extremities. The knee-jerk did not reappear in any case, and there was no change in the Argyll-Robertson pupil. This suspension treatment was applied by M. Blocq to a girl aged thirteen, with Friedrich's disease, and after a course of thirty trials there was decided improvement in the tremor and instability. In two cases of neurasthenia and impotence there was great return of power, as Dr. Motchoukowsky had found. In a case of disseminated sclerosis the treatment was followed by a spasmodic paraplegia, which disappeared after three days, when the treatment was stopped. Much more experience will be necessary before the results of this treatment can be judged of, but as far as it has been carried hitherto it has done no harm.—*Le Progrès Médical; London Practitioner*.

**STROPHANTHUS.**—Since the publication of Professor Fraser's paper on Strophanthus, at the Cardiff meeting of the British Medical Association in 1885, sufficient time has been given for a comparison of the effects of the new remedy with those of other cardiac tonics. The subject is one which interests a wide circle in the profession, as is evidenced by the large number of communications which have appeared regarding it in this country, in America, and on the Continent. Although it has been abundantly shown that strophanthus is a drug of great value in many cases in which a cardiac tonic is indicated, and has, in the hands of many observers, satisfactorily fulfilled all the results expected from it, yet the opinion has also been frequently expressed that it is less

successful and less trustworthy than digitalis. Many of the failures have been due, doubtless, to the use of tinctures made from unripe or otherwise faulty seeds; but now, when good preparations are readily obtainable, the same opinions continue to be expressed. The disappointment is owing probably to too high expectations being formed of the efficacy of the drug in disease, and probably, also, to its use in unsuitable cases.

Digitalis itself does not prove of benefit in a certain proportion of cases, otherwise there would not be such frequent attempts to introduce new substitutes for it. It has, besides, various subordinate actions which render its use dangerous or unpleasant. It is, however, undoubtedly too much the custom to employ digitalis and similarly acting substances whenever a diuretic effect is desired without considering that their use is rational only in certain conditions. To understand what these conditions are, it is necessary to determine the main physiological actions of the digitalis group, and then fix, as far as we can, what benefits and what unpleasant consequences may reasonably be expected to result from these actions. All the members of the group are muscle poisons, and, when taken in therapeutical doses, prolong the diastole of the heart, cause it to beat more slowly, and to discharge at each contraction a larger quantity of blood into the arterial system. At the same time the arteries become contracted and well filled, and the blood-pressure is raised above normal. Owing to all the blood passing through the heart, it receives a much larger supply of the drug than the other muscles do, and is, relatively to them, profoundly influenced. In health diuresis is not, or only very slightly, increased.

The disagreeable effects are vomiting or nausea, colicky pains, and sometimes diarrhea. They occur whether digitalis is given by the mouth or subcutaneously, and are due to the action of the poison on the muscles of the alimentary canal. Digitalis preparations have also a cumulative action, the reason being that two of its active principles—digitalin and digitoxin—are very insoluble, in consequence of which absorption and excretion are so irregular that at times a large amount accumulates in the blood and causes symptoms of poisoning. Probably, however, the so-called cumulative action is frequently blamed for what is the result of overdosing, the tincture of digitalis being, as a general practice, prescribed in too large doses. Lastly, we have no digitalis body which is suitable for hypodermic use, as they all cause more or less local irritation. Some of the best known members of the group are convallamarin, adonidin, scillain, strophanthin,

helleborein; and they are all, so far as we know, identical in physiological action. But as much can not be said for the tinctures and other preparations made from the crude drugs; for instance, digitalis leaf contains four active principles, three of which have the digitalis action, while the fourth resembles saponin, and is physiologically antagonistic to the others. *Convallaria majalis* contains a second body, convallarin, which causes violent diarrhea.

The best crude drug to use, therefore, for making our pharmaceutical preparations, would be one which contains only a single active principle, and this readily soluble. We should thus introduce into the stomach a single substance easily absorbed and readily excreted, and which, if given at stated intervals, would always circulate in the same amount in the blood. So far as we yet know, strophanthus seeds fulfill these conditions. It has been claimed for strophanthus that it acts more promptly and more certainly than digitalis, and that it differs from the latter in not causing contraction of arteries. This last opinion was derived from experiments on frogs, which have been confirmed by Langgaard; but Phillips, Thomson, and Langgaard himself have shown that in the case of mammalia contraction of vessels is caused just as with other members of the group. The first mentioned claim is probably well founded, the regularity and promptness of action being due to the solubility and consequent ready absorption of strophanthin.

To come to the cases in which cardiac tonics are specially of benefit; they are briefly those in which, owing to cardiac weakness, the arteries are not well filled, while the veins become overfilled, and in consequence of the back pressure venous stasis with dropsy results. The administration of any member of the digitalis group strengthens the heart and regulates the distribution of blood, the arteries become full, the veins are relieved, the arterial pressure is raised, and the serous exudation is reabsorbed into the blood-vessels. This makes the blood too watery, and the excess of water is got rid of by the kidneys. Hence the increased diuresis ceases as soon as the dropsy has passed off. There is no direct action on the secreting renal epithelium, the increased flow of urine being simply the result of the altered conditions of the vascular system.

In weakness and functional irregularity of the heart, and in emphysema with relative insufficiency, a cardiac tonic may also be reasonably expected to do good.

From what has been said we can not hope that digitalis will act well as a diuretic in cases where the blood-pressure is already normal or above normal, and the arteries well filled, as in

many cases of chronic nephritis, in pleurisy, and other local exudations. Its use in such cases will only be attended with disappointing results; but in cirrhotic kidney, with consecutive dilatation and weakness of the heart, its administration is often of great service.

The advantages of strophanthus over digitalis are summed up in the facts that it acts more promptly as a rule and has no cumulative action, while it shares with digitalis the disadvantages of causing disturbances of the alimentary canal, and local irritation when administered hypodermically.

Further investigation of the many plants having muscle-poisons for their active principles may provide us at any time with a more satisfactory substitute for digitalis.—*British Medical Journal*.

**PERIPHERAL NEURITIS.**—The second number of the *Archives de Médecine Expérimentale* contains three papers bearing on the subject of peripheral neuritis. The first, by MM. A. Joffroy and Ch. Achard, adds one more to the growing catalogue of conditions associated causally with this affection. It is based on the record of a case in which well-marked symptoms—as persistent and severe pain, followed by muscular paresis, and wasting of all the extremities—occurred about nine months before the patient's death from an attack of cerebral hemorrhage and pneumonia. Degeneration of nerve fibers was found in the main nerve trunks of the limbs in varying degree, but in all more marked in the peripheral nerves. In addition, there was found obliterating arteritis in the nerves—for example, in the sciatic—and it was to the resulting loss of nutrition that the "neuritis" was attributed. Indeed, a parallel is drawn between the changes thereby produced in a nerve trunk and those of cerebral softening from arterial thrombosis. It is remarked that, had the patient not succumbed to pneumonia, senile gangrene would have developed, and might have been referred erroneously to the neuritis; whereas both conditions would have owned the same origin, viz., obliterating arteritis. The next paper, by the same authors, deals with a case of tabes, complicated with cutaneous gangrene, in the left great toe, but with neuritic changes far more marked in the nerves supplying some of the other toes. Hence the writers do not attribute the gangrene to the neuritis, nor could they assign pressure as its cause; but refer the gangrene as well as the neuritis to the disease of the cord. Another factor in the production of peripheral neuritis in this case was the presence of tuberculosis, from the effects of which the patient died.

The third paper, by MM. Déjérine and Sollier, comes as an instructive pendant to the foregoing, since it deals with the subject of "peripheral tabes," to which M. Déjérine had previously drawn attention. The case was one of a man fifty-four years of age, who for fifteen years had suffered from incoördination of the lower limbs, marked lightning pain, and disturbance of sensation. The patellar reflex was, however, present. This patient also died from phthisis. The spinal cord and nerve roots were found to be healthy, but there was very marked peripheral neuritis, especially in the cutaneous nerves of the lower limbs, less marked in the muscular nerves, and slight in the cutaneous nerves of the hands. The sciatic nerves were quite normal. It is pointed out that the recognition of peripheral tabes, due to neuritis, involving mainly sensory nerves, is of practical value, since peripheral neuritis is often curable. The etiology of the case was obscure, neither alcoholism nor tuberculosis (although both had at one time or another been present) accounting for it.—*London Lancet*.

**THE PHARMACY AND PHARMACOLOGY OF THE NITRITES.**—The chemistry and pharmacology of the nitrites were the subject of several valuable contributions and an instructive discussion at an evening meeting of the Pharmaceutical Society lately held in London. The introductory address was given by Professor Dunstan, who gave a general account of the constitution and properties of the nitrite group (.ONO). He especially insisted upon the primary necessity of preparing the various compounds *in a pure state*. Pharmacologists have too frequently worked with specimens which they have assumed to be pure without previous testing by a scientific chemist. Thus a highly impure solution of ethyl nitrite has long been employed in medicine, and is still included in the British Pharmacopeia under the name of spiritus etheris nitrosi. Again, the "amyl nitrite" of the Pharmacopeia is very far from being a homogeneous substance; it is a mixture of several substances in indefinite proportions, containing, it is said, thirty to forty per cent of substances other than amyl nitrite, viz., nitro-pentane, amyl nitrate, amyl alcohol, valeric aldehyde, valeric acid, and in addition to these (or most of these) no less than ten per cent of iso-butyl nitrite; the amyl nitrite itself (only fifty per cent) existing as two separate compounds, the  $\alpha$ - and the  $\beta$ -. Special interest attaches to the three last-named bodies. Iso-butyl nitrite has been separated by Professor Dunstan, and proved by Professor Cash to bring about a rapid fall of blood pressure, an acceleration of the pulse, and great respira-

tory paralysis. In these respects it is even more powerful than a mixture of the  $\alpha$  amyl and  $\beta$ -amyl nitrites, the individual actions of which are being now investigated. In the subsequent discussion Dr. Lauder Brunton pointed out that the nitrite of amyl so-called, as purchased in the shops, varies in the effects it produces to a very considerable extent. The pure nitrite of amyl does not produce such a marked action as the commercial specimen; and in all probability the explanation is that given by Professor Cash, that butyl nitrite is the most powerful of the two, and that the commercial article contains a large percentage of it.

A communication on the ethyl nitrites, of great interest to the practitioner, was next made by Professor Leech, of Manchester, who has already made a special study of the therapeutical properties of the pharmacopeial solution. (*Practitioner*, xxxi, page 241.) His researches relate to the comparative effects of spiritus etheris nitrosi and a solution of nitrite of ethyl, the former answering to the tests of the Pharmacopeia, the latter a 2.25 to 2.7 per cent solution of ethyl nitrite in absolute alcohol containing five per cent of glycerine. Both compounds dilate the vessels and decrease tension, and both remove undue contraction of the muscular coats of the bronchial tubes, but neither has any powerful and constant influence on the skin or kidneys. Professor Leech has not been able to discover any difference between the action of the spirit and that of the solution, nor that they differ in their action on the kidneys. At times a slight increase in the urine flow seems to occur after both, but more often no change is observed. They are both therefore of equal and great value in dilating vessels and in relieving an overloaded heart. In a word, it would appear that the solution of the pure nitrite will answer every medical purpose served by the official spirit. Another question of importance is whether the time-honored spirit ought not now to be banished from the Pharmacopeia on account of its ready decomposition. The percentage of ethyl nitrite in it may fall as low as 0.3 per cent after six months' keeping.—*London Practitioner*.

**PULMONARY SYPHILIS.**—In commenting upon a case of lung disease (*La France Médicale*, No. 27) of two months' duration with signs of consolidation at the right base, M. Potain concludes that the diagnosis of the syphilitic origin of the condition was fairly warranted. The case was apyrexial, there were no apical signs, and the patient had formerly contracted syphilis. At the same time he admits the rarity of observations on the subject, and states that a

Russian author (not named), among 21,757 *post-mortem* examinations, found syphilis in 23 per cent. Visceral syphilis was only present in eighty-eight cases, and in eleven of these there were pulmonary lesions. He also affirms that pulmonary syphilis always attacks the right side. The lesions met with in the lungs are gummata, or sclerosis, the latter being marked by thickening of the alveolar walls and accumulation of epithelium within the alveoli; or there may be a combination of these two lesions, or the gummatous change may take on the character of a diffuse infiltration. There is also a condition described as "white hepatization." As a rule, the middle portion or apex of the lung is the seat of the syphilitic change; but in about one fifth of the cases the lesions may be limited to the base. The presence of gummata alone may not be revealed by physical signs, but, as with tubercle, they may excite inflammatory changes around them. Perhaps further diagnostic aid might be gained by the detection in the sputum of Lustgarten's bacillus, but M. Potain does not seem to lay much stress on this, and points out that the microbe, if such there be, is not likely to be found in the stage of simple congestion or of non-softened gumma.—*London Lancet*.

**THE EARLY RECOGNITION OF CANCER OF THE CERVIX UTERI.**—Impressed by the frequent complaint of patients in the New York Cancer Hospital, that their attending physicians never told them that any thing serious was the matter until their condition had become hopeless, and convinced that general practitioners need to be taught that the successful treatment of uterine cancer depends on their early recognition of its presence, Dr. Coe gives, in the *Medical News*, February 16, 1889, the result of his observations upon this subject, attempting to combat certain fallacies which are generally accepted, and to point out certain reliable points in the early diagnosis of the disease. Over one fifth of the recorded cases occur in patients under forty years of age. The disease may reach an advanced stage without producing cachexia. Many, in fact most, of the patients at the hospital have been singularly free from pain, which, when it does occur, is a later symptom due to peritonitis. Profuse foul watery discharge is not always present, even when there is extensive ulceration. Slight, irregular hemorrhages, occurring after coitus or in the intermenstrual period, should arrest attention, as they frequently result from incipient cancer. Premature climacteric hemorrhages (between thirty-five and forty) are usually pathological. In all cases in which a patient over forty years of age

seeks advice with symptoms (specially hemorrhage) referable to the pelvis, a careful examination should be made. The pain attending incipient epithelioma may be sharp, or merely a dull backache, or a neuralgia of adjacent nerve trunks, as the sciatic. Hypertrophy and general induration of the cervix, accompanying an erosion which bleeds easily when touched, should lead the physician to excise a generous wedge of the suspected tissue, including both the mucous membrane and the subjacent muscular tissue, and to submit this to microscopic examination. Excision of the cervix should be performed in every case of extensive erosion with general induration, whether cancer has actually developed or not.—*Maryland Medical Journal*.

IS SYPHILIS INCURABLE?—Private G. W. contracted primary syphilis in March, 1882. In September, 1883, he was admitted into the station hospital, Bangalore, with secondary syphilis. At this time there was a well-marked rash on the body and legs. Under treatment by alteratives he recovered and was discharged to duty. During June, July, August, and September, 1884, he was again under treatment, and during this time suffered from disease of the nasal bones, condylomata, nodes on the tibiae, and ulcers on both legs.

He was treated with mercury, iodide of potassium, and tincture of iodine at different times. On September 12, 1884, he passed an invaliding board, and was sent to a hill station for a change. During 1885 he had four admissions for secondary syphilis, spending a total of one hundred and thirty-six days in hospital. Since 1885 he has been free from syphilitic manifestations, but there still remain well-marked syphilitic scars over both tibiae. In January, 1889, he again contracted primary syphilis, and was admitted into the hospital with a typical Hunterian chancre. This has been followed by induration of the glands in the groin, a roseolar rash, and ulceration of the throat. Since his present admission he has been treated with perchloride of mercury and iodide of potassium, and under this treatment the symptoms are rapidly disappearing.

No one can dispute the truth of Dr. Althaus' assertion that "it is now generally accepted, whatever views may be entertained by different observers about the nature of contagium, that whoever has syphilis can not acquire it. A single well-observed case of reinfection in the same individual, therefore, clearly shows that syphilis is at least occasionally cured."

In the case given above the facts are indisputable, as they have been carefully recorded in the man's medical history sheet by the dif-

ferent medical officers under whose care he has been. It seems strange that such eminent authorities as Drs. Gowers and Drysdale maintain that syphilis is an incurable disease. Had they stated that we can never declare with absolute certainty in any individual case of syphilis that the patient is completely cured, no one would have questioned the statement. When, however, they maintain that syphilis is incurable, it is quite a different matter; and I believe that most persons who have had experience in the treatment of syphilis will disagree with them.—*G. Harrison Young, Surgeon, A.M.S., British Medical Journal*.

A TRACHEOTOMY TUBE IN THE BIFURCATION OF THE TRACHEA.—A somewhat remarkable case is reported by Professor Pieniczek in the *Przegląd Lekarski*, where a caoutchouc tracheotomy tube, which had been inserted ten years previously, suddenly slipped and fell down the trachea so as to be completely lost to sight. At first, the patient, who was an elderly man, coughed violently, but after a little while the irritation entirely ceased, and though he could feel the presence of the foreign body at the third and fourth costal cartilages on the right side, it did not occasion him any serious inconvenience. It had remained *in situ* about seven weeks when it was removed. In order to accomplish this the patient was chloroformed, and as sufficient anesthesia for the purpose was not procured by this means, the mucous membrane was painted with a twenty-five-per-cent solution of cocaine. By means of a laryngoscopic mirror introduced into the laryngeal opening, the foreign body could be distinctly seen and its position made out. It was lying at the bifurcation, its convexity upward, and its larger end directed toward the right bronchus. With the help of the mirror, a blunt hook was passed down to the tube in such a manner that it was caught up and so extracted. Professor Pieniczek remarks that it would have been almost impossible to secure the tube without the aid of the mirror, as its position could not otherwise have been determined, and without an exact knowledge of this any manipulation with instruments would have been dangerous and probably useless.—*London Lancet*.

MORPHINE IN PUERPERAL CONVULSIONS.—I was sent for to see a woman after delivery by my assistant. She had one fit after another. She was a thin, pale, weak woman, so I could not bleed, and chloroform did no real good. As it is known from *post-mortem* experience that there is no real mischief in the brain, a happy thought struck me to try hypodermic injection of morphine. I rode home three miles and re-

turned at once with the syringe, and at once injected a grain of morphine. This was about twelve o'clock in the day. I called again about 6 P. M., and she had had only one more convulsion, which was just before I arrived. I gave her another hypodermic injection of nearly a grain of morphine, and I may date her recovery from that moment.

The other day I was sent for to a stout, strong, florid woman with strong convulsions. I examined her, and found that labor had just commenced. I saw no reason to interfere, as the child was sure to be born in its own proper time; this was about mid-day. The child was born about 6 P. M. I hoped that then she would get better; but at 10 P. M., as the convulsions still continued and were getting stronger, I injected a full grain of morphine, and she had only one slight convulsion after, and made a perfect recovery.

Having been so successful in these two cases, I certainly shall follow the same treatment in the future. Knowing, as we do, the *post-mortem* state of the brain, there can be no danger in giving a powerful opiate; and then, again, it lessens the liability to peritonitis afterward. Bleeding I have tried before delivery with success, combined with chloroform; but I have found chloroform after delivery fail most miserably, although it has calmed the convulsions; but then it did not cure. In both these cases I have recorded, though of exactly opposite types, the patients had only one slight convulsion after the injection of a grain of morphine. I might write a great deal more of the why and the wherefore of this matter, as to the danger of this thing and the difficulty of that; but I hope your readers will think it over, and, when they find their own endeavors fail, let them try an injection of a grain of morphine, and not be afraid of the results.—*Mr. Alfred Grace, British Medical Journal.*

**CALOMEL AS A DIURETIC.**—Massius prescribes three grains, thrice daily; adding extract of opium gr.  $\frac{1}{4}$  to each dose, if the calomel purges. During the first two days the urine may be diminished; diuresis being established on the third or fourth day, when the quantity of urine excreted may reach eight or ten pints. When free diuresis has been obtained the medicine is suspended. The drug is uniformly certain in its action. Minute precautions must be taken from the first to prevent stomatitis, especially by gargling with chlorate of potassa.

In one case of advanced nephritis, gangrenous stomatitis developed on the second day, diuresis not being manifested. Moderate diarrhoea does not interfere with the diuresis. The tension and volume of the pulse are

not affected, though when diuresis occurs the heart's action is accelerated indirectly; the calomel causing the excess of liquid to disappear, and relieving compression in the vascular tract, thus permitting the blood-wave to reach the periphery with greater force. The author does not admit the local irritant action of calomel upon the renal epithelium.—*Bull. Gén. de Thé., Medical Times.*

**CYSTICERCUS CELLULOSÆ OF BRAIN.**—A. B., aged about sixteen years, was sent to the hospital by Dr. Henderson, suffering from symptoms of cerebral compression, the result of a fall. He died a few days after admission. The *post-mortem* examination showed the cause of death to be intracranial hemorrhage. The surfaces of the cerebrum and cerebellum, especially along the longitudinal fissure, were studded with numerous small cystic-looking bodies with clear fluid contents; the majority of them were about the size of a split pea, and altogether there were some sixty to seventy of these bodies present. Several, I found on removal, had undergone such calcareous degeneration. Some were placed in spirit, and the contents subsequently examined with the microscope. The cysts then revealed themselves as the cysticercus cellulosæ. The other parts of the body were not examined for them. The patient being unconscious the whole time he was in the hospital, of course I can not say that any symptoms indicating the presence of these bodies existed; and I am unable to find out any thing of the boy's previous history; most probably there were no previous symptoms.—*Dr. J. L. C. Cox, British Medical Journal.*

**SYPHILITIC PHTHISIS.**—The characteristic signs and symptoms which distinguish the syphilitic form of the disease are chiefly an absence of well-defined physical features in its earlier stages; frequently the only evidence of the disease being a wavy respiration or an impaired respiratory sound. However, when crepitation appears, it commences suddenly, and is usually of a loud, moist character, and may diffuse itself very rapidly over the whole side of the chest. Hemoptysis is generally a prominent factor; there are no persistent, well-defined fever and night sweats; the expectoration is frequently tough, white, stringy, and abundant; the patient, as a rule, is anemic, subject to diarrhoea and vomiting; the marked anorexia and wasting do not appear early; and any change which occurs in the course of the disease, either toward recovery or death, is

generally more marked and sudden than in the ordinary form.

The absence of fever, or the tendency of the fever to assume an irregular or abnormal course, I regard as one of the most valuable symptoms in differentiating this form of phthisis. Whenever I meet with a constant low temperature in such cases, my suspicion of infection is always aroused, in spite of the absence of other satisfactory evidence. *Dr. Mays, in the Polyclinic.*

**VERNEUIL ON MICROBISM AND ABSCESS.**—Verneuil proposes to no longer classify abscesses as hot and cold, idiopathic and symptomatic, but etiologically, according to the nature of the bacteria that produce them. For our modern knowledge of the process of suppuration we have to thank three methods—microscopic researches with staining re-agents, cultures, and inoculation experiments. We now know that every sample of pus contains bacteria, and the abscess contents may be *mono-microbique* or *poly-microbique*. The bacteria of pus may be divided into two groups: the first are constantly present in all pus, and are characteristic of it (the different micrococci and diplococci, streptococci, zoöglea, staphylococcus pyog. aureus, citricus, albus, etc.); the second are only found occasionally (various micrococci, bacteria, vibrios, bacilli, etc.). The first Verneuil calls pyogenic microbes proper; the latter, accidentally pyogenic microbes ("pyocoles"). Verneuil divides abscesses into (1) simple abscess, containing only the "pyogenic microbes proper;" (2) infecting abscess, in which the accidental bacteria also occur. He already enumerates sixteen varieties of abscess occurring with particular infectious diseases, and containing specific bacteria. Variola, syphilis, and chancre do not find places in the list, their bacteria not having as yet been isolated, though certainly they will yet be found.—*Edinburgh Med. Journal.*

**EFFECT OF SLEEP ON THE GASTRIC JUICE.**—Some investigations which have been recently carried out in Professor Manassein's wards in St. Petersburg, by Dr. S. L. Rappoport, on the effects of sleep on the secretion of the gastric juice are published in the last few numbers of the *Vrach*, and tend to show that the digestive functions of the gastric juice are materially affected by sleep. The experiments were made on the human subject, the gastric juice being withdrawn by means of a flexible india-rubber esophagus sound, the introduction of which is said not to have caused any inconvenience to

the subjects of the research. The quantity of the gastric juice secreted during sleep was shown to be very much less than that secreted during waking hours; the chloride of sodium, as well as the hydrochloric acid, were diminished; but the secretion of pepsine did not seem to be much affected. By means of experiments conducted in the laboratory, it was found that the digestive power of gastric juice secreted during sleep was lower than that secreted during waking hours, the difference apparently depending mainly upon the lack of hydrochloric acid. With regard to the rennet ferment, Dr. Rappoport was unable to demonstrate any alteration in its secretion during sleep.—*London Lancet.*

**INJURIES EXTRAORDINARY.**—In the Medical Press and Circular Dr. Thomas Hayes, the medical officer of Rathkeale Union Hospital, gives an admirable account of four cases of serious gunshot wounds treated successfully. In the first, a heavy charge of double duck shot passed from the axilla to the point of the shoulder. The joint presented an excavation three or four inches in diameter, filled with a mixed mass of fragments of bone, cartilage, blood, and debris. The axillary vessels had escaped, though the head of humerus, coracoid and acromion processes were all shattered. The case was conducted to an excellent recovery, with a useful limb, by judicious treatment. The second was a servant girl, who seems to have taken a good deal of trouble to shoot herself accidentally with a revolver bullet between the fifth and sixth left ribs within an inch of the sternum. Though collapsed, pulseless, and vomiting after the accident, the bullet was never found, and no bad symptoms followed. The third was a wound of the hand caused by the explosion of a rusty rifle. The parts were so shattered that amputation could have been done by scissors, but by patient antiseptic dressing and drainage a useful limb was left. The fourth was a similar case, even worse, with a similar good result. Dr. Hayes believes in the virtues of what he calls the anti-tetanic pill, which is 1 gr. each of calomel, aloes, and opium, to be taken every night. The cases are well told, and the results excellent.—*Edinburgh Med. Journal.*

**SACCHARIN AS AN ANTISEPTIC.**—According to an article in a French medical journal, saccharin may be very usefully employed as an addition to mucilaginous and other solutions which are apt to develop fungi, as it enjoys the property of preventing the formation of low organisms, even when it is present in only very

small proportions. A strength of 1 in 500 is sufficient to prevent the development of staphylococcus pyogenes aureus, and a strength of 1 in 200 the development of B. termo. Thus a valuable but inexpensive dentifrice may be prepared by simply dissolving saccharin in water to the proportion of 6 per cent. A teaspoonful of this in a half pint of water forms an admirable antiseptic mouth-wash. In cases of malignant or other disease of the stomach requiring the washing out of that organ, a solution of saccharin of the strength of 2 per cent will, according to this authority, be found very suitable. As a quantity of twenty centigrams, or about three grains, can be taken during the day without detriment to the digestive functions, the addition of the minute amount necessary to render mucilaginous solutions permanent can not be regarded as in any way injurious.—*London Lancet*.

**NASO-PHARYNGEAL TUMORS.**—At the January meeting of the Edinburgh Medico-Chirurgical Society Professor Annandale read a paper on the Removal by Operation of Naso-pharyngeal Tumors. He stated that his principal object in reading this paper was to describe a method of operating carried out successfully in three cases recently under his care. He had studied the many and various methods previously suggested and practiced for the removal of these growths, and although his own method was not original in some of the details, he believed that in its entirety the procedure was new. Having freely admitted that some growths in this region might be removed by other than a cutting operation, he described the steps of his procedure as follows: (1) The exposure of the anterior nares by freely dividing the mucous membrane connecting the upper lip and upper jaws according to the plan of Rougé. (2) The division of the bony septum of the nose along its attachment to the jaw. (3) Incising the soft parts along the middle line of the hard palate, and then sawing through the alveolar margin of the upper jaw, and through the entire hard palate along the same line. The soft palate may or may not require division in its middle line. (4) The forcible separation of the two jaws, and the introduction, through the gap of the finger, of the periosteal scraper or other similar instrument, with a view of separating the secondary connections of the growth to the surrounding parts. (5) The removal of the growth from its primary site of origin by forceps, sharp spoon, cold snare, or galvanic wire. After the operation the two jaws are brought together and retained by one or more sutures. Professor Annandale believed that his operation had for the first time demon-

strated the fact that the upper jaws, after such a section, could be separated to an extent so as to give access to the base of the skull and posterior nares. Three cases recently operated upon with success were then reported in detail.—*Edinburgh Med. Journal*.

**LOCAL TREATMENT OF DIPHTHERIA BY CALOMEL.**—Dr. Gustav Elwert, of Reutlingen, has found great benefit from the local application of calomel in cases of diphtheria. His idea was that, if calomel could be brought into contact with the diphtheritic membrane, the chloride of sodium in the saliva would act upon the mercury salt and produce corrosive sublimate in minute quantities, which might, however, be sufficient to act as a bactericide to the virus in the membrane. His plan is to mix calomel with two or three times its weight of powdered starch, and to brush out the pharynx lightly with a feather dipped in this powder. This is done three or four times during the day and two or three times during the night. Cold-water compresses are applied to the throat, and a mixture containing nitrate of sodium is prescribed for internal administration. The effect of the treatment is soon apparent in the diminution of the membranous patches and of the foul odor, and, where the disease has invaded the larynx, in the decrease of the hoarseness of the voice.—*Lond. Lancet*.

**HEMATOMA AURIS OR THE "INSANE EAR."** Brown-Séquard produced hemorrhage into the auricle in guinea-pigs by section, and by irritation of the restiform body of the same side. This appears to me to suggest that hematoma auris is sometimes a peripheral trophic lesion, and comparable to analogous peripheral lesions met with in morbid conditions of the central nervous system—as, for example, in Charcot's disease. On this hypothesis, the restiform bodies might be regarded as either trophic centers for the auricles, or, at all events, intimately associated with such centers. On this view, such slight traumatism as habitually sleeping on, for example, the left ear (especially if the pillow were hard) would act as an exciting cause of hemorrhage in the auricle of an individual predisposed to degenerative changes. *Mr. William Hill, British Medical Journal*.

**QUININE AND ANTIPYRINE.**—Dr. Dulon associates these two remedies together. By a mixture of 15 centigrams of antipyrine and 25 centigrams of quinine he obtained antipyretic effect equal to that produced by 75 centigrams of quinine and without producing the symptoms of quinism nor stomachal intolerance.—*Revue de Ther., Medical Times*.

# The American Practitioner and News

"NEC TENUI PENNÂ."

Vol. VII. SATURDAY, APRIL 27, 1889. No. 9.

D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } - - - Editors.

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## ARREST OF PHYSICIANS FOR MAN-SLAUGHTER.

The recent arrest of two practicing physicians on the charge of manslaughter, and the incarceration of one of them in jail in default of bail, in Louisville during the last week, is a matter deserving of more than passing notice. It seems that the two doctors in question were attending a negro woman in labor, and, according to their own admission, they were both drinking. One of them declined the responsibility involved in instrumental delivery, and the other confessed that he was not acquainted with the use of the forceps. The woman died undelivered.

The woman's mother swore out a warrant, charging the two medical men with manslaughter, and both were arrested.

Without at all passing judgment on the case, or expressing any opinion in the particular premises as to what punishment the individuals in question may have deserved, we think the precedent of prosecution in this form is not to be encouraged.

Jefferson County has a coroner whose duty it is to investigate just such cases, and if an arrest and prosecution was the proper thing, it ought to have been inaugurated by him.

If the ignorant relatives of a patient who may happen to die under medical care may swear out a warrant and have the attending physicians sent to jail, any doctor is liable to be served in this manner whose cases of midwifery may not come out as the relatives think they ought, thus inflicting a disgrace that can never be recovered from.

It is to be hoped that if such steps are deemed proper to be taken at any time in the future, they will be left to the coroner or the grand jury.

## A NEW STATE MEDICAL SOCIETY.

We published in our last issue a circular sent out by order of the Franklin County Medical Society, suggesting and advising the formation of a new State medical society based on the principle of representation. It is confessed that something needs to be done to arouse interest throughout Kentucky in the matter of medical societies, especially of the State Society.

It does not speak well for Kentucky doctors that Indiana can secure an attendance of four or five hundred at her State Society, and Tennessee, on our southern border, can get an attendance of three hundred or more, while the Kentucky Society does well to go beyond a half a hundred.

But we much doubt if the course advised by the Franklin County Society would result in mending matters. There is certainly in this State no division of the profession into different camps that would cause a competition that would result in an aggregate attendance greatly larger than it is now.

No one doubts that the methods of our State Society need improving, and the very fact of such protests as the Franklin County Society offer is evidence of a determination to improve them.

This reform can easily be made within the present State Society, and doubtless will be made in the near future. The last few years have witnessed a great increase in the railroad facilities of the State, which will tend to increase the attendance at our medical societies, and a little vigilance and care will eliminate political methods from the proceedings.

## YELLOW FEVER IN FLORIDA.

News comes from Florida that the yellow fever has broken out at Sanford, an enterprising and progressive town situated at the head of navigation on the St. John's River and near the center of the State.

The Board of Health is said to be confident that by the complete isolation of the one case, and careful hygienic measures, the spread of the disease may be prevented. It is sincerely to be hoped that its efforts may be successful.

The outbreak of an epidemic of yellow fever so early in the season, enabling the disease to spread throughout the South, and possibly even the entire country, before autumn, would be a disaster of incalculable proportions. For the next few weeks news from the infected locality will be awaited with deep anxiety.

## Notes and Queries.

**ANTIFEBRINE.**—There is absolutely no difference, chemically or therapeutically, between antifebrine and acetanilid, except in the price, the former costing about double the market value of the article. A manufacturer of salapson could with equal right sell his product as *anti-constipine*, or some other copy-rightable name, and ask ten or fifteen cents per pound.

Acetanilid (phenylacetamid) is a white crystalline powder, having no smell, and only a slight odor; it is almost insoluble in cold water, but soluble in hot water, in alcohol, and in wine; it melts in  $120^{\circ}\text{C.}$ , and boils without decomposition at  $292^{\circ}\text{C.}$ ; has neither acid nor basic properties, and resists decomposition by most re-agents. It is given in doses of from 0.2 to 0.5 gram in tablet or capsule form, or in wine; the total amount given within twenty-four hours should not exceed 2 grams. According to Drs. Cahn and Hepp, it produces prompt apyrexia best by the administering of large doses at long intervals, and acts quickly and four times as strongly as antipyrin. Its action is without disagreeable effect on the nervous system and stomach.

Acetanilid has long been known as a chemical compound, but its value as an antipyretic

was only lately discovered, and the general investigation of its therapeutical uses then followed.

It has been employed with excellent results as a pain-reliever in neuralgic and rheumatic affections, as a sedative, as a febrifuge, as an antipyretic, and the medical press teems with communications pointing out other uses.

The articles put up by Kalle & Co., under the arbitrary, copy-righted name "*Antifebrine*," is of the same chemical composition ( $\text{NHC}_6\text{H}_5\text{C}_2\text{H}_3\text{O}$ ), and absolutely identical in its nature and effects with acetanilid.—*Notes on New Remedies.*

THE ANNUAL MEETING OF THE NATIONAL ASSOCIATION OF RAILWAY SURGEONS will be held at St. Louis, Missouri, on Thursday and Friday, May 2 and 3, 1889.

The prospects are that this will be one among the largest gatherings of medical men ever assembled in this country.

Dr. W. B. Outten, of St. Louis, is the Chairman of the Committee of Arrangements, and every thing will be complete for the accommodation of the surgeons.

Any information desired can be had by addressing the secretary, C. B. Stemen, M.D., Fort Wayne, Indiana.

MICHIGAN STATE MEDICAL SOCIETY, 1889. The twenty-fourth Annual Meeting of the Michigan State Medical Society will be held in Kalamazoo, Thursday and Friday, May 9th and 10th, next, and preliminary arrangements for it are already completed.

Railroad certificates for reduced fare will be sent to all physicians, other than members, who desire them, on application to the Secretary.

BATTLE CREEK, MICH. S. S. FRENCH, M. D.,  
President.

QUACKERY.—In Chicago, March 13th, the Appellate Court affirmed a decision that, notwithstanding the opposition of the State Board of Health, a physician may advertise. Dr. J. Cresap McCoy, the specialist, advertised largely, and the State Board revoked his license. According to the Appellate Court the Board is now prohibited from interfering with the advertising physician.

**PHENACETIN AND LACTIC ACID.**—Incidental mention was made recently of the solubility of phenacetin in lactic acid at a temperature of 33° C., and of the suggestion of Messrs. Mirrachi and Raffi that its rapid absorption, when administered, notwithstanding its comparative insolubility, is due to the occurrence of lactic acid in the stomach. It is now further suggested (*Pharm. Zeit.*, December 15th, page 753) that the occasional failure of the compound to produce the expected relief from neuralgia or headache may be due to the absence of that acid from the stomach and the consequent imperfect absorption of the phenacetin, the inference being that the difficulty might be overcome by the addition of a little lactic acid.—*Pharm. Journal*.

**THE BACTERIOLOGY OF TETANUS.**—On the 8th inst., before the Royal Medical Academy of Turin, Drs. Belfanti and Pescarolo gave an interesting report of their later studies on the bacillus tetani. Quite recently they have been able to isolate the same micro-organism already discovered by them and described to the Academy in May, 1888; and they have found that in their experiments Nicolayer's bacillus produced neither tetanus nor death, while the mixtures made from pure cultures of the three bacilli, to wit, their own, Nicolayer's, and Rosenbach's, if they produced death, did not develop tetanus.

### SPECIAL NOTICES.

**NOTE ON BROMIDIA AS A HYPNOTIC.**—By Edward Warren-Bey, M. D., C. M., LL.D., Chevalier of the Legion of Honor. The success which this drug has achieved in France is somewhat remarkable. The French as a nation are remarkably conservative in every thing save their politics, adhering tenaciously to the ideas and objects with which they are familiar, and regarding with corresponding suspicion all novelties and innovations, especially those coming from abroad. Hence it is that the materia medica of France has not marched *pari passu* with that of its neighbors. The bromidia (Battle) at once attracted the attention of the French physicians, and their experience with it so developed their confidence in it as a prompt, reliable and harmless hypnotic that, in utter disregard of all that they had been taught and believed respecting the danger and unreliability of alien products, they promptly accorded it a place in their repertoire of remedial agents, and are now using

it as freely as any medicinal preparations included in the Codex. In no other country, in fact, does it enjoy a larger measure of popularity than in France, and so great is the demand for it that it has been found necessary to manufacture it here in large quantities in an establishment especially arranged and organized for that purpose.

As no extraneous influences have been brought to bear in its favor, it has had to make its own way in the face of opposition and prejudice of the most formidable character, upon the strength alone of its virtues as a remedy for insomnia and other corresponding disturbances of the nervous system, the conclusion is legitimate that it really possesses the therapeutical properties claimed for it, that it is a hypnotic *par excellence*, and without a rival.

To those familiar with the use of Bromidia (Battle) no argument like this is necessary, for it speaks for itself by fulfilling the indications for which it is administered with a certainty, efficiency, and harmlessness which elicit at once the delight of the prescriber, and give to the profession the assurance of possessing one remedy at least which approximates so near to infallibility of action as to justify the title of *specific*.—*Medical Press and Circular*, London, England, March 27, 1889.

**UTERINE STYPTIC.**—John Adderley, M.D., Skibbereen, County Cork, Ireland, says: It gives me great pleasure to add my testimony to the great value of S. H. Kennedy's Extract of *Pinus Canadensis*, which I consider a most valuable uterine styptic, seeming not only to possess the power of arresting uterine hemorrhage, but also to produce a healthy action of the parts. I used it with a patient who had been suffering for a number of years from menorrhagia, depending upon ulceration of the os and cervix uteri, with whom I had tried all other remedies for menorrhagia lasting during a period of five months almost without intermission. Extract of *Pinus Canadensis* applied to the os uteri on cotton wool, and also used as a lotion, arresting the hemorrhage immediately; and the Aletris Cordial, which was taken internally, helped to invigorate the system and promote a cure which I had at one time considered incurable. I should not wish to be without these remedies in similar cases, and shall continue to use them in my practice, as I consider they gave most satisfactory results.

**SYPHILITIC ULCERATION OF THE SOFT PALATE.** Dr. I. W. Condict, of Dover, N. J., writes: I have recently witnessed satisfactory results from the persistent administration of *SUCCUS ALTERANS* in an aggravated case of the destruction of the tonsil, velum, and all surrounding parts, where iodide of potassium had been exhibited more than two months in liberal doses, even as high as four hundred grains per day continually for three weeks of the time, and had failed to arrest the progress of the disease.

(We personally know Dr. Condict as a physician of large practice, much above the average in education, and one of the most successful physicians in New Jersey. Coming from him the above is a very high commendation.—*Ed. Mass. Med. Jour.*)

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÂ."

VOL. VII.  
[NEW SERIES.]

LOUISVILLE, KY., MAY 11, 1889.

No. 10.

*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.*—RUSKIN.

## Original Articles.

### BICHLORIDE OF MERCURY IN ANEMIA.\*

BY A. M. CARTLEDGE, M. D.

*Demonstrator of Anatomy, Kentucky School of Medicine.*

Mercury, when properly given, is without doubt a greater benefit to a larger class of sufferers than any remedy we are acquainted with at the present time. This or that year discovers the enterprising therapist in quest of some vegetable substitute for this time-honored agent, but an impartial trial results in a return to the "old love." It may be there is something better in the great storehouse of nature, but it has not yet been discovered. Because a thing has been with us long, we are apt to feel a familiar acquaintance and fail to acquire a thorough knowledge of its properties. It would be well for us to adhere to the maxim to "study that which is good." To Keyes belongs most of the credit of first calling attention to the small doses of mercury in the treatment of syphilis. This was an advance step of great importance, as it raised the profession from the position of doing syphilitic subjects a great injury by treatment to one of imparting the greatest benefits. I have elsewhere, in a paper on mercury in syphilis, spoken at length on this subject. What is desired to especially call attention to in this paper is the wonderful potency of mercury, more particularly the protochloride, as a tonic and curative agent in most forms of anemia. I am aware the explanation of this will appear to most physicians to be the

specific taint which underlies so many of these cases. However, I beg to believe that it exercises its influence for good in cases when syphilis by heredity, remote or otherwise, is no factor in the case. Admittedly, the minute pathology of anemia is obscure, many times depending on organic lesions of varied character and situated in different organs. The evidence of anemia, viz., impoverished red blood cells or diminution of red blood cells, does not enlighten us as to the cause of this phenomena.

The shortest as well as the most accurate way of estimating the virtue of mercury in anemia seems to be, first, to fix in our minds what we know the salts of mercury capable of doing when introduced in the system; second, to study many of the organic lesions, together with their pathological anatomy, which are secondarily, at least, causative elements of anemia; third, to make the application.

Under the first head comes the known power of small quantities of mercury to cause absorption of lymph deposits anywhere in the system, probably by its stimulation of the glandular system, more probably by relieving the gland structures of embarrassment to action, the impediment being micro-organisms which irritate the walls of afferent and efferent ducts, producing engorgements—the mercury acting as a germicide. Its known action outside the body, together with its influence on morbid processes in the body, does more to strengthen the germ theory of disease than any one corroborative fact.

Take these properties alone, viz., its power to cause lymph absorption and its influence in relieving glandular engorgement, whether of the great glands, as the liver, kidneys, etc., or of the lymphatic system, and I dare say nearly every pathologist will agree that you have an agent indicated in nine out of every ten cases

\*Read before the Louisville Medico-Chirurgical Society, March 29, 1889.

of anemia. The deduction is, that while iron has its sphere in feeding the impoverished red cell—and we have abundant proof that it does—and while the salts of Peruvian bark and arsenic do meet specific causes of anemia, yet the presence of the deleterious influences soon produce structural changes which are most effectually met by mercury. Of course it maintains pre-eminence as a specific agent in syphilis.

This article would be more incomplete without a word as to the form of administration for the tonic and alterative effect. While I must express a preference for the proto-iodide in the so-called primary and secondary stages of syphilis, I think, where impoverishment of the red corpuscles has taken place, or in anemia without syphilis, the bichloride is the preparation to use. The union with the hydrochloric acid seeming to greatly increase the tonic effect, I often give it in doses as small as the  $\frac{1}{64}$  of a grain well diluted on a full stomach. A most excellent combination is that of the protochloride of mercury, chloride of arsenic, and chloride of iron as prepared by Messrs. Renz & Henry, of this city, under the name elixir of three chlorides.

Take the anemia of females, the subject of disease connected with the organs of generation, and I know of no one constitutional remedy the equal of this drug. Nearly all of these cases are the subject of lymph deposits and ovarian congestion, which is best met by an agent which so decidedly facilitates healthy gland action. In the chlorosis which is so often a manifestation of struma the bichloride of mercury with iron will often effect a cure where iron alone fails. We appreciate the great good mercury does, especially as calomel, in relieving acute glandular engorgement. What I think we need most to be impressed with is its great virtue in relieving those often obscure and chronic obstructions to gland action which exert so potent an influence for evil in the economy.

LOUISVILLE.

A CONGRESS of physiologists will be held at Bâle, beginning on Tuesday, September 10, 1889.

## CLINICAL FEATURES OF CANCER OF THE UTERUS, WITH ITS TREATMENT.\*

BY CORNELIUS SKINNER, M. D.

*Professor of Principles and Practice of Surgery, Hospital College of Medicine, Louisville.*

Like leprosy of old, there is no disease seen or written of in modern times that is more dreaded than cancer in any of its forms, especially when attacking the uterus. It is not the purpose of the writer to take up pathologically cancer, but to bring up for discussion two points of practical interest, viz., first, symptoms which indicate treatment, and, second, two modes of treatment.

Since it is generally admitted and taught by all authorities on cancer that the disease is at one time local, afterward becoming general, our symptoms naturally are divided into two stages, as in all other diseases of a like nature.

A disease more insidious in its onset is not known, hence it is that the physician and even the gynecologist often overlooks or fails to recognize what he has to deal with.

It has not been the writer's good fortune to see this form of cancer in its beginning; and even those who have written especially upon the subject fail to throw any light upon its incipient symptoms, all saying that one of the first things noticed will be a watery discharge, which was supposed by the patient to be the "whites" (all women being more or less subjects of this discharge), or, when blood is present, a period.

At first there is little or no pain and no odor. Upon ocular and digital examination, in many cases, a condition of the cervix will be found identical with endometritis with laceration; and, owing to an inherent desire upon the part of the gynecologist not to find and the patient not to have cancer, we can not wonder at the mistake. Unfortunately for the woman, she rarely presents herself for treatment before well-marked symptoms of that second stage force her to seek medical advice. Pain becomes severe, and with the increase of discharge there is a most horrible odor—nothing equals it. Finally, after sexual intercourse, or some other form of exertion,

\* Read before the Louisville Medico-Chirurgical Society, April 12, 1889. For discussion see page 298.

there comes on a profuse hemorrhage, sometimes fatal. With this to meet him at the door, a doctor is called in. Digital examination now discloses an enlarged cervix, usually covered by a soft friable tumor, which is easily broken down by the slightest touch, thereby increasing or renewing the hemorrhage.

Aside from those changes which are often wrought by a copious loss of blood, there is to be seen in the face of such patients a certain indescribable expression which, when once recognized, is as ominous to the initiated as a sudden fall of barometer to the sea-tossed mariner. To this has been given the name of cachexia, that peculiar waxy appearance to be seen in every case, indicating profound and extensive lymphatic obstruction.

*Treatment.* If there has been any difficulty in making an early diagnosis, there is still greater doubt and difference of opinion as to the best mode of treatment, some adhering to local treatment exclusively, while others are equally loud in condemning it, but insisting upon total extirpation of the entire uterus and surrounding diseased tissue.

Local treatment has for its object prolongation of life, not by any hopes of eradication of the disease but by a retardation of its progress. The means by which this is accomplished are numerous, and every decade comes up with some sure cure. Celsus, with his copper scales, did apparently good service; but this soon gave way to better and more reliable caustics, chloride of zinc, nitric acid, nitrate of mercury, etc. These all are objectionable, first, on account of slow action, secondly, our inability to limit them to diseased tissue. We then were asked to use the cautery—hot iron, thermo and electric. The heated iron was cumbersome, and soon fell into disfavor. Paquelin's requires a shield for the vagina, and even then unnecessary pain is produced by heating the vaginal walls. The electric is easier handled, and is much more satisfactory in its work; in a few seconds we can cut away any protruding mass that may exist, and at the same time thoroughly cauterize the cervix or diseased base. Equally as satisfactory is the curette, used until sound or firm tissue is reached, afterward applying powdered iodo-

form or boracic acid, the latter acting at the same time as a neutralizer of the odor. With any form of local treatment it will be necessary to irrigate the vagina with some antiseptic or deodorizer, as carbolic acid, bromochloralum, Platt's chlorides, diluted, etc. This is considered by many the treatment giving the best results in prolongation of life or even permanently removing the disease. The first statement may or may not be true. As to the other, I must say it does seem to me to be devoid of any scientific support, and those who have claimed permanent eradication afterward admit a probable mistake in diagnosis. Some two years ago a long article appeared, saying we had found a sure cure for uterine cancer, lupus, etc., in the shape of a paste (alveloz), an extract from the Brazilian milk-weed. This went the rounds, and was tried in our own city—one case I know and treated—the drug acting as any other caustic, removing the superficial part of the growth, which would rapidly return, the curette doing a work as effectually in a few seconds that it took the alveloz weeks to accomplish.

Total extirpation was first done successfully through the vagina, in 1828, by Blundell, of England. The operation was looked upon as not only bold but too reckless to be considered legitimate or surgical, and soon passed into oblivion. But as time passed surgery has been lifted from its association with things belonging to the dark ages into the brilliant light of scientific medicine, giving us our modern surgery, with all its far-reaching and undreamed of practice, until, in the language of Cordes, who, when speaking of American surgeons in connection with this subject, said: "The word impossible is next to unknown. Vaginal hysterectomy has been developed, and is now looked upon as the haven of cancerous woman." This will and does have its opponents as ovariectomy had, and while until within the past few years the death-rate has been twenty-eight per cent. Martin, of Berlin, comes out in his report of sixty-six cases with only eleven deaths. With this improvement one can readily see what will be the result. The operation will be done oftener.

## THE SCOPE OF THE CURETTE IN GYNECOLOGICAL AND OBSTETRICAL PRACTICE.

BY ANDREW F. CURRIER, M. D.

It is but a few years since it was determined that more or fewer of the so-called constitutional diseases have a local origin, and that they are susceptible of successful treatment by local means during this primary stage. This statement is verified by the many successes in the treatment of tuberculosis, scrofula, sarcoma, carcinoma, etc. This fact marks a great advance in surgical pathology and therapeutics. While the antiseptic principle lies at the foundation of the matter, there is no instrument which has been of greater utility in accomplishing this result than the curette. There is scarcely an epidermal, serous, or mucous surface appertaining to the interior or exterior of the body which is not susceptible to some form of disease in which the curette may be of service. This paper discusses only its application to obstetrics and gynecology, and the principle involved in its use as a cutting, bruising, or scraping instrument. No one who practices obstetrics and gynecology can afford to be without some form of the instrument; it is as indispensable as the obstetric forceps or the speculum. Whether the instrument is of ancient origin is at present immaterial. Récamier is at least the modern inventor of the instrument and the operation for which it was designed. It was called by him a *sonde-curette* or a *gorgeret-curette*, and it was employed by him in 1846 as a means for the treatment of "vegetating endometritis" (*An. de Thérapeutique*, August, 1846). Bonreau, whose article on the curette is the most exhaustive that has ever appeared (see *Nouv. Arch. d'Obst. et de Gyn.*, March, April, May, June, 1888), divides its history into three periods, the first extending from 1846 to 1860, when it fell into practical disuse, at least in France; the second from 1860 to 1872, the period of obstruction and partial oblivion; and the third, from 1872 to the present time, in which it was restored to popularity, which popularity

continues. Most of its former opponents are either silent or have been convinced of its usefulness, and the danger now is that its too free use will lead one to forget that the uterus is still a most sensitive organ which will not tolerate reckless or injudicious treatment. Vulliet has coined the suggestive word *curomania* for the rage which exists in certain quarters for curetting the uterus for all ills, real or imaginary, to which the uterus may be subject. As Bonreau has said, curetting is intended only for chronic conditions with the one exception of that acute condition in which portions of placenta or membranes have been retained after mature or premature parturition. Among the distinguished advocates of the curette may be mentioned Simon, Schroeder, Hegar, and Olshausen in Germany; Simpson, Tait, Barnes, and Duncan in England; Sims, Thomas, and Goodell in America; Récamier, Lisfranc, Nélaton, and Dóleris in France, and others in Switzerland, Scandinavia, Denmark, Spain, Italy, and Russia. In introducing the curette Récamier was compelled to face the antagonism of such men as Dubois, Velpeau, Aran, and Becquerel, while the instrument was opposed in Austria and Germany by Carl Braun, Scanzoni, Spiegelberg, Hildebrandt, and Beigel. The opposition of Great Britain was led by West, Churchill, Atthil, and Bennett, and in this country by Emmet. Terrillon advocated the use of the curette for cancer in 1855, and Simon in 1872, the latter modifying the Récamier instrument so that it became more effective, but also more dangerous. Sims attached great value to the instrument, and made useful modifications, but it was still a cutting instrument. Lisfranc was the first to make use of a dull curette (1847), the general indication for its use being "bloody and white discharges." Thomas has given us the best modification of the dull curette, which is comparatively safe and useful except in those forms of disease in which large quantities of tissue are to be scraped away. In France no one has done more to revive the use of the curette and indicate the lines of its usefulness than Dóleris; and it may be

said that he has constituted the existing French school for the advocacy of the instrument. The curette has two functions, the diagnostic and the therapeutic, and it is difficult to say which is the more important and valuable. When used for diagnostic purposes it is but a prolonged index finger, and its manipulation should be so gentle that no disturbance of existing conditions will be excited at the same time that accurate information concerning those conditions is elicited. There are many cases in which it is difficult or impracticable to introduce the finger into the uterus for diagnostic purposes, there are very few in which the curette may not be so introduced. The indications for the therapeutic use of the curette are, (1) hemorrhage, (2) mucus or mucopurulent discharges, (3) sepsis, (4) pain. These may all be present in a single individual, or there may be but one of them. If inflammation is present, and it is acute in character, it would be improper to use the curette. The chief indication is uterine hemorrhage, excluding the normal hemorrhages of menstruation and parturition. The latter are physiological when not exceeding a few drams or a few ounces; all other uterine hemorrhages being pathological, and an indication of disease or violence. The hemorrhage may proceed from:

- (a) A diseased mucous membrane.
- (b) Disease affecting the parenchyma of the uterus, especially from new growths.
- (c) Disease of the uterine adnexa.
- (d) Disease of the pelvic peritoneum or cellular tissue.
- (e) Stasis from uterine displacements.
- (f) New growths and adventitious tissue in the uterine canal.

The indication for curetting is not equally clear in all these conditions. Récamier recognized a condition of hyperplasia of the uterine mucous membrane, and it was for this condition that he devised the curette, the definite object being to arrest hemorrhage. His many published cases show that he was remarkably successful with the instrument. Since Récamier's time many others have studied this hemorrhage-causing

condition of the mucous membrane, variously recognizing it as a granular, an hyperplastic, a polypoid, or a fungoid condition. Among such investigators are Bischoff, Hegar, Olshausen, Simpson, Routh, and Savage. Hemorrhage from the mucous membrane is very common in connection with malignant disease. The use of the curette is only palliative, but it brings great temporary relief from hemorrhage and from the offensive discharges which characterize such processes. Hemorrhage also arises when the uterine parenchyma is affected with either malignant or benign disease. The latter includes the entire class of fibroid growths, which become more troublesome and give rise to freer hemorrhage as they encroach upon the mucous membrane, especially if located near the os internum in the area of greatest vascularity of the uterus. Curetting for such cases is very beneficial, but it is also only palliative. Hemorrhage may be due to congestive and inflammatory conditions of the ovaries and fallopian tubes, and curetting will be useless, unless the process extends to the uterine mucous membrane. Uterine congestion and hemorrhage may attend disease of the pelvic peritoneum and cellular tissue, the latter existing irrespective of disease in the tubes and ovaries. The accumulating evidence of the past few years has demonstrated with certainty, however, that disease in the tubes and ovaries is the source of pelvic disorder far more frequently than would have been admitted ten or even five years ago. For the acute forms of this disease curetting should not be performed, but in cases in which the mucous membrane is in a chronic degenerated condition, which frequently follows the acute disease, curetting will be efficient.

Copious hemorrhage frequently attends uterine displacements, especially posterior ones, and this is apt to be unusually troublesome during the menstrual epoch. A rational explanation for this would seem to be the stasis which results in the uterine veins from mechanical obstruction, and this is one of the many facts which gives importance and significance to displacements of the

uterus. With continued engorgement will result hypernutrition of the uterine mucous membrane and curetting will furnish a means for temporary relief. The radical cure must come only when the mechanical obstacles are removed. Uterine hemorrhage may be due to uterine polypi or to the retention of fragments of placenta or decidua, and for the latter the relief which may be obtained by the use of the curette is prompt and satisfactory. To summarize this subject of uterine hemorrhage, if it accompanies degeneration, infiltration, hyperplasia, or chronic inflammatory changes in the uterine mucous membrane, there is no treatment so satisfactory as careful and thorough curetting, performed under anesthesia and with antiseptic regulations, and followed immediately by the application of an astringent or caustic antiseptic solution.

The use of the curette is indicated for the treatment of muco-purulent discharges from the uterus, especially in connection with chronic catarrhal inflammation of the glandular system of the cervical mucous membrane. The operation is simple and usually painless, and may be done with almost absolute safety. It is better to do it a week after the cessation of menstruation, when the pelvic congestion has entirely subsided. It is far more satisfactory than swabbing out the discharges with cotton, removing them with a syringe or simply coagulating them with a layer of iodine or other astringent. Sepsis is not an infrequent concomitant of the conditions which have been under discussion. The warmth and moisture of a closed or nearly closed cavity like the uterus are favorable to the decomposition which usually ends in more or less well-defined sepsis. The curette may not remove the septic influences which have been disseminated through the thousand mouths of the uterine lymphatics, but it may stop the tide of such influences; and the rapid changes for the better in septic cases in which curetting has been done demonstrate that the poison may be rapidly eliminated, and that if we can stop the current before the vital powers are overwhelmed our chances of success are very

good. Statements similar to the foregoing may be made concerning pain, which is a secondary symptom among the indications for curetting. If the cause really lies in the tissues which are curetted, the operation will cause the pain to disappear, and that this does occur is a matter of too common observation to require argumentation. The operation in general is one which calls for so little skill that it is within the reach of every general practitioner, and there is no general practitioner who does not at some time or other encounter conditions which call for its performance.

NEW YORK.

#### EPICYSTIC SURGICAL FISTULA FOR CYSTOSCOPIC EXPLORATION, INTRA-VESICAL TREATMENT, AND DRAINAGE.\*

BY JOHN D. S. DAVIS, M. D.

Epicystotomy has become an established and frequently practiced procedure, and the danger incident to opening the bladder through the abdominal wall is so slight that patients suffering from almost any vesical trouble are encouraged to have the bladder opened for diagnostic purposes and treatment at a time when the general health remains unimpaired, a practice which a few years ago would not have been resorted to by the most aggressive surgeon.

Catarrh of the bladder, irrespective of its cause, is always followed by a series of consecutive pathological changes which, independently of the partial or complete interruption of the passage of the urine, tend to destroy life. A dilatation of the bladder and ureters by retention of urine may give rise to such a degree of distension as to destroy life from suspension of important functions by mechanical pressure. During the stage of inflammation a paretic condition may occur, the blood-vessels in the vesical wall lose their support, and transudation and exudation take place into the paravascular tissue, which, combined with capillary stasis attending this stage of the disease, re-

\*Read before the State Medical Association of Alabama, April 11, 1889.

sults in sloughing, infiltration, pyemia, peritonitis, and death. The damming up of the urine may, and does often, cause surgical kidney, epididymitis, and tetanus.

The treatment of chronic vesical catarrh resolves itself into a consideration of the causes producing the disease, many of which, the presence in excess of certain inorganic constituents of the urine, stone, stricture, and hypertrophy, are capable of correction; while others, such as malignant tumors and certain conditions of the prostate, may only admit of a palliation of the symptoms to which they give rise, and the removal of which must be the first object in treatment. But when a parietic condition of the bladder exists, provision must be made for the complete continuous emptying of the viscus, its thorough cleansing by frequent irrigation with hot sterilized water, and the promotion of a healthy tone in the mucous membrane and muscular structure of the bladder. The frequent introduction of catheters for drawing off residual urine and washing out the bladder has been productive of much harm, and, instead of giving relief, proved to be, by reason of their frequent introduction into the inflamed bladder to draw off the urine two or three times a day, a source of immediate and alarming symptoms. These facts are cogent reasons for adopting surgical means in all cases of intra-vesical troubles as soon as a diagnosis can be made, and often when it can not otherwise be made, for the complete emptying of the bladder, thorough cleansing, diagnosis, and intra-vesical treatment.

The epicystic surgical fistula is designed for drainage, intravesical treatment, and cystoscopic exploration, and may be divided for consideration under the following heads.

I. Definition of epicystic surgical fistula.

II. Surgical resources in the formation of the epicystic surgical fistula.

1. Preparation for the operation.
2. Anesthesia.
3. Position.
4. Incision and opening bladder.
5. Intra-vesical exploration and treatment.
6. Toilette and after-treatment.

III. Advantages of the epicystic surgical fistula.

1. Cystoscopic exploration.
2. Intra-vesical treatment.
3. Drainage.

#### I.—DEFINITION OF EPICYSTIC SURGICAL FISTULA.

Epicystic surgical fistula is the title here given to a supra-pubic fistula into the bladder created by the surgeon for exploration, intra-vesical treatment, and drainage. A fistula which, acting as an artificial urethra, is capable of giving free access to the inside of the bladder for cystoscopic exploration, to provide a ready, convenient, and comfortable means of emptying the bladder at will, and gives the surgeon a competent opening into the viscus for intra-vesical applications.

It constitutes an essential element in the speedy and complete evacuation of the contents of the bladder in all epicystic operations, and imitates nature in the restoration of its own continuity and repair as the pathological changes within the bladder subside.

#### II.—SURGICAL RESOURCES IN THE FORMATION OF THE EPICYSTIC SURGICAL FISTULA.

(1). *Preparation for the Operation.* The presence of two assistants, though not necessary, may be of valuable aid. A temperature of 80° or 85° F. should be maintained in the operating-room from the beginning to the end of the operation. All hair is to be shaved from the pubis, and all the details of antiseptic surgery are to be carried out so far as cleaning the pubis and abdomen. The bladder is emptied and thoroughly washed with warm water. When the water returns clean the bladder is slowly distended with warm sterilized water thrown into the bladder by means of a fountain syringe, with nozzle in urethra—a degree of pressure sufficient to distend the bladder to its utmost capacity, which can never be too great for the resistance of the bladder. It is better to fail in filling the bladder than to distend the bladder beyond the limit of competency. Indeed it is not necessary to fill the bladder to any degree of resistance. I have operated when the bladder was in an irritable condition and would not tolerate distension greater than the

capacity of two ounces, and had no difficulty in avoiding the prevesical fold of peritoneum or finding the bladder. The water is secured in the bladder by tying the penis at the base with a rubber tube.

A colpeurynter is next to be well oiled and inserted into the rectum—the rectum having been previously emptied by enema—and filled with warm water. This distension brings the bladder into view above the pubis.

(2). *Anesthesia.* My preference for chloroform is the result of my own personal experience with it. It is not free from objections, as its depressing effect on the heart is well known. The operation usually occupies fifteen minutes, and, hence, its prolonged use would be unnecessary and uncalled for. The objection to ether is the suppression of the excretions and the frequency with which bronchitis is produced when administered to persons advanced in years. The best course to pursue, when the operation is prolonged, is to follow the use of chloroform by ether. The patient must be kept profoundly under the influence of the anesthetics from the first incision until the superficial wound is closed.

(3). *Position.* The patient is placed on the back, on an ordinary operating-table, with the legs extended as if in a position for perfect comfort and rest. Many surgeons claim advantages in the position recommended by Trendelenburg. Eigenbrodt emphasizes the fact\* that the elevation of the pelvis in Trendelenburg's position† helps the surgeon to avoid the prevesical peritoneal fold at the time of the incision of the bladder.

I have employed this posture for intra-vesical operation by means of the supra-pubic incision with no advantage over the ordinary flat-back position. With two openings in the bladder for a continuous stream of clear water, I have no trouble in illuminating every part of the bladder with the electric surgical light, and am thus enabled to examine the entire intra-vesical wall. Undoubtedly the position recommended by Trendelenburg possesses advantages which, to the author more than myself, make it highly

ideal. As for myself I prefer and recommend the flat-back position.

(4). *Incision and Opening Bladder.* A perpendicular incision three or four inches long is made in the median line above the symphysis pubis. The recti muscles are separated to symphysis. If the pyramidalis is in the way, the fibers should be cut. The transversalis fascia is divided on a grooved director from symphysis to within one inch of upper margin of superficial wound. Instead of following Guyon's maneuver, I catch the bladder with a tenaculum on a line with the symphysis, through the prevesical fat, and cut through with a bladder-knife into the bladder with one smooth, clean incision, to prevent undue disturbance of the cellulo-adipose tissue between the bladder and pubis and avoid infiltration. I have never seen a case where it was necessary to put up the prevesical fat, and with it the peritoneal *cul-de-sac*. If the bladder is caught on a line with the symphysis and cut downward, no fears need be had for the peritoneum. Cutting this prevesical fat prevents its after dropping down over the opening into the bladder and acting as a valve to prevent easy escape of urine and causing infiltration. And, too, such a procedure gives a smooth incision throughout, and it is almost impossible to have infiltration, even when no drainage-tube is left in the bladder, and the urine is left to flow out through the fistulous track and taken up by a layer of absorbent cotton. In making the incision into the bladder, no attention is to be paid to any vein or veins which are sometimes met with. If cut, they will stop bleeding when the bladder is dropped back and the rectal bag removed. The operation is usually bloodless in the sense of hemorrhage. I have operated without the patient losing more than one dram of blood.

(5). *Intra-vesical Exploration and Treatment.* The finger is carried into the bladder and a thorough search made for any tumors, villous growths, or foreign bodies. The bladder is now emptied and the rubber around penis untied and the bladder well washed out with hot sterilized water. The bladder can now be examined with the cystoscope and surgeon's electric light. If tumors be found, if practi-

\* L. c., p. 72. Cf. Lang, Medical News, December 4, 1886.

† In Trendelenburg's position the patient's legs are held over the shoulders of an assistant with the body resting on an incline table, much in the position which hogs are swung for spaying.

cable they should be removed; villous growths and any foreign body should be removed. If nothing is found in the bladder, the surgical fistula, in the absence of malignancy, will be all that is required to relieve the cystitis.

(6). *Toilette and After-treatment.* The bladder is allowed to drop back into the pelvis, and the superficial wound so closed by two sutures (including the skin and superficial fascia only), in the lower portion of the incision and one in the upper portion of the incision, as to leave a fistulous track of equal size from bladder to juncture of upper third and middle third of the superficial incision. A large rubber catheter is now to be introduced into the bladder through the opening, and its distal extremity allowed to enter a urinal placed in the bed between the patient's thighs, or preferably at the patient's side. Professor F. Trendelenburg, director of the surgical clinic of the University of Bonn, proposed, for draining the bladder in supra-pubic lithotomy, the T-tube in latero-abdominal position, and open-wound treatment as the simplest, safest, and best. He makes an antiseptic dressing of iodoform gauze around the T-tube. There can be no real necessity for a tube of any kind to be introduced into the bladder for the purpose of conveying the urine from the bladder to prevent infiltration, irritation of superficial fascia and soiling of dressings.

If the urine is kept acid by the administration of citric acid or some other palatable acid drink, no better antiseptic than the acid urine can be secured for the constant bath of the parts. It should be allowed to flow out through the wound and absorbed by a pad of absorbent cotton placed loosely over the wound, and removed as often as soiled by the outflowing urine. By this method of emptying the bladder no possible small amount of urine can be impeded in its outflow, which is the case around and outside of the tube when catheter or tube is left in for any length of time—a source of no little annoyance at times. This little collected or retained urine, around the outside of the tube alone, I have seen produce a hard chill and elevation of temperature, and become for the time an immediate, alarming, and aggravating source of trouble. I never have

seen the skin made sore or chafed by the overflowing urine in epicystotomy, or from its after escape through the surgical fistula.

The bladder should be washed out twice daily with hot sterilized water, by means of a fountain syringe, with its nozzle introduced into the urethra, the water escaping through the epicystic fistula and guided into a bed-pan under the patient. The superficial stitches are taken out at the end of a week, and intermittent catheterization by the fistula is then resorted to for the sole purpose of draining the fistula and to prevent its rapid closure. It is not necessary to catheterize for the purpose solely of drawing off the urine. In one case I never drew the urine save for the purpose of analysis, but occasionally introduced a rubber bougie to prevent the closure of the fistula. The drainage by the fistula alone is admirable, and the fistula will be well formed in twenty or thirty days, competent to retain urine without dripping, and to allow its escape in a good projecting stream at will. With no tearing of the tissues, and, with a clean cut, the drainage is perfect and the dangers are nil.

### III. ADVANTAGES OF THE EPICYSTIC SURGICAL FISTULA.

(1). *Cystoscopic Exploration.* Nitze has, by means of the cystoscope, been enabled to diagnose tumors of the bladder in nine cases in which rectal palpation, the sound and other means had furnished negative results. One of the great difficulties in the cystoscopic exploration of the bladder is the presence of pus, mucus, and sometimes blood, which renders it exceedingly difficult to maintain a translucency of the fluid used to distend the bladder. By means of a simple fountain syringe a constant current of clear water may be kept within the bladder, so essential to a complete observation of the trigonum Lieutaudii, the most interesting part of the viscus, the ureters, and to examine any affection of that viscus. The fistula may be made for temporary purposes of cystoscopy by the Peterson-Guyon-Perier operation; but I can see great advantages from a different operation by Dr. Hunter McGuire, the object of which tends to eliminate as well as detect the trouble within the viscus, and, too, in the final

construction of a permanent fistula, gives an easy after-method of exploration, and makes a better artificial method by reason of its length and extension upward of two to three inches. Diagnostic purposes are met by the possibility of immediate detection of all local conditions, such as tumors, calculi, foreign bodies, neoplasms, the collection of fluids from the ureters, etc.

(2). *Intra-vesical Treatment.* Having by means of the epicystic exploration revealed the true nature of the intra-vesical trouble, the treatment resolves itself into the immediate necessities of the case. For instance, prostaticectomy may be necessary, villous papilloma may be found and should be remedied; pedunculated growths may be found which should be removed by the scissors or Paquelin's cautery, etc. In such cases the opening in the bladder sufficient to introduce the finger should be enlarged downward under the symphysis pubis, and the operation indicated should at once be performed. The object of the formation of the permanent surgical fistula is to meet the after-indications in such operations, the details of which do not properly come within the province of this discussion. However, it is sufficient to state, what is reasonable and practicable, that a better means by which the intra-vesical wall can be reached and treated therapeutically has not yet been devised.

(3). *Drainage.* Permanent after-drainage in all intra-vesical operations can not be necessary, but is highly essential to secure good and sufficient drainage until the para-vascular tissue is disengorged, the cystitis is relieved, and the urine becomes normal and passes *per urethram* unobstructed. And until this end is attained complete artificial arrangement for the escape of the contents of the viscus must be made. In such cases of prostatic hypertrophy or malignant growths, when removal of the obstruction is impossible or contra-indicated, the epicystic surgical fistula is clearly indicated and essentially necessary. It meets every possible indication for local treatment, and gives the only controllable, ready, and free drainage to viscus and kidneys. Urinary back-pressure, as the result of incompetency of the urethra

from the various immovable prostatic troubles, is often an immediate and remote cause of surgical kidney, which can only be removed or relieved by supra-pubic drainage. In conditions of the bladder of long-standing cystitis, as in the case reported by me in the *Virginia Medical Monthly*,\* in which the urethra, though made competent by cutting, was not sufficient to keep the bladder emptied without catheterization—a procedure which kept up a constant vesical inflammation, which, combined with capillary stasis attending the inflammatory process, resulted in paresis.

I now have the pleasure of introducing that case, Mr. T. A. Nixon, to you fifty-eight days after the operation. His condition to-day is sufficient guarantee for all I have said in favoring the formation of an epicystic surgical fistula for the relief of chronic vesical catarrh. The result in this case is more than I promised. He can retain his urine several hours, and without dripping of urine or pain to bladder; urine completely under control and bladder relieved of pain.

BIRMINGHAM, ALA.

## Societies.

### LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, April 11, 1889, Vice-President, Dr. J. M. Ray, in the chair.

Dr. C. Skinner read the essay of the evening: subject, Cancer of the Uterus. (See page 290.)

#### DISCUSSION.

Dr. John G. Cecil thought, with the essayist, that the future would develop satisfactory methods of treatment in cancer uteri. Extirpation is now the only treatment worthy of consideration. What we need is the ability to make an earlier diagnosis. As yet we have no sign which, in the earlier stages of the disease, we can safely rely on. If we must wait for pain, tumor, and the characteristic odor, it will be too late for effective treatment. The microscope is the only thing that gives promise of making the desired

\**Virginia Medical Monthly*, April, 1889; *Alabama Medical and Surgical Age*, April, 1889; *New York Medical Journal*, April 13, 1889.

early diagnosis. Recently the speaker saw a Boston surgeon remove a piece of suspected uterine cancer by means of a cutting punch. The piece removed represented the neoplasm to its full depth, and enabled the microscopist to make a diagnosis in time for the operation to be of great avail. An operation, to be of real value, must remove every particle of affected tissue. According to Dr. Hunter the greatest difficulty is in the early diagnosis of the disease, and this point is generally agreed on by gynecological surgeons. When extirpation is not indicated only palliative measures are to be thought of; curetting, iodoform, and irrigation with disinfectants are then of service.

Dr. H. A. Cottell did not believe it yet possible to tell with certainty by the microscope that a uterine growth is cancerous. The cancer cell has no characters, as a rule, which distinguish it from other cells of the epithelial type. Fragments of tissue from the cervix uteri usually show great proliferation of epithelial elements; but it is only when these can be seen invading the uterine muscular fiber that a positive diagnosis of cancer can be made. *If the surgeon would always include, in the piece of tissue removed for microscopic study, a portion of the contiguous uterine muscle, the microscopist would oftener arrive at correct conclusions.*

Dr. Ap Morgan Vance said: Whenever and wherever cancer is extirpated there is great danger of return: we must watch the statistics to see whether operation really prolongs life, and, if so, for how long. It would be well to inquire, further, whether cancer of the uterus is less prone to relapse than cancer elsewhere.

Dr. Bailey: It is of great interest to see how closely pathology and physiology are related. Malignancy in cancer would seem to be simply the invasion of the cells belonging normally in one tissue into tissues of different histological structure and their final usurpation of the greater part of the nutrition due that part. Where there is recurrence after operation it shows that the extirpation was incomplete—total removal would seem not to allow of return. Aveloz,

the much-vaunted new remedy for cancer, will go the way of condurango. It is simply an escharotic.

Dr. Cottell: The point made by Dr. Bailey as to the kinship of pathology and histology is strikingly true; there is nothing new in pathology except microbes. When cancer returns it is probably because of lymphatic infiltration. A gland of normal size, and at a distance from the tumor, may be the center of a fresh outbreak. The true nature of cancer is involved in mystery.

Dr. Skinner, in closing the discussion, said: The diagnosis must rest chiefly with the attending physician, close study and observation of the clinical history, rather than with the pathologist. It is easier to give contra-indications to the operation than clear indications for it. Statistics are not reliable, reports are made too early, and the successes are too numerous as compared with bad results.

#### REPORTS OF CASES.

Dr. D. T. Smith reported a case of chronic labio-glosso-pharyngeal paralysis or associated bulbar palsy.

The patient, a rather free drinker of fifty-two years, whose health had been bad after performing some customary tasks, on rising, remarked to a servant that he was "done for," and, sinking down, had to be carried to his bed. At first he was almost entirely unable to articulate so as to be understood. In a few days he rallied somewhat, when close examination revealed an associated bulbar palsy of certain bulbar nerves.

There was a marked inability to articulate the sound of the letters *l*, *n*, *r*, *t*, as well as *m*, *p*, and *b*. Contrary to the rule, the deficiency was greatly marked as to the letter *g* from the beginning. There was a choking sensation in the throat with distinct difficulty in swallowing. The secretion of saliva was great and annoying in the extreme.

Speech is much better in the morning than in the evening, fatigue rapidly impairing the power of articulation. There was no paralysis elsewhere, and evidently the alarming symptoms were due to an acute temporary

congestion. Close inquiry developed the fact that the difficulty of speech had persisted for some time previously, being most decided in connection with fatigue.

The involvement of nerves evidently embraces the lower part of the roots of the facial, the hypoglossal, the spinal accessory for the larynx and probably the palate, and the glossopharyngeal for the pharynx. The throat symptoms were likely due to involvement of some fibers of the pneumogastric. The exact pathology of this disease is not clearly made out. In some cases only degeneration of the anterior pyramids has been made out. In this case the seat of lesion is indicated between the facial and the hypoglossal nuclei.

The treatment has been stimulating and tonic, with iodide of potassium, phosphorus, and strychnine. The prognosis is grave. The main hope of treatment is by carefully guarding against excessive activity to prevent the spread of the disease and to stimulate the unaffected cells.

Dr. William Bailey had been consultant in the case.

Dr. Vance asked if a metal plate had ever really been used after compound comminuted fracture of the skull to protect the brain when a portion of the skull was wanting.

Dr. W. L. Rodman did not believe any modern author mentioned it; a few old books make reference to it.

Dr. Rodman reported a case of suppurative synovitis of the finger, with necrosis of the phalanges and the head of the metacarpal bone. The patient is a woman ninety-three years old. She is well nourished, but the heart gives a distinct mitral regurgitant murmur. She has also bronchitis.

The use of ether is contra-indicated by the latter; is chloroform contra-indicated by the former? Should an operation be done?

Dr. Vance advised the use of cocaine in the case. None of the Fellows advised the use of a general anæsthetic, and none were bold enough to say that they would be willing to assume the responsibility involved in giving chloroform in such a case.

S. G. DABNEY, M. D.,  
Secretary.

## ALLEGHANY COUNTY MEDICAL SOCIETY.

Special Meeting, March 19, 1889, William F. Knox,  
M. D., President, in the chair.

Dr. Duff: Two months ago I reported a case of rheumatism, or, rather, a case of rheumatism associated with eruptions around the joints. At the time I did not understand the case, and could not say what the outcome would be. The rash was first papillary, then vesicular, following up in the order of the joints attacked. A few days after I found several large blebs over the shoulder, just such as we have arise after the application of cantharides plaster. As they dried up the submaxillary glands and cervical glands began to enlarge, and continued until suppuration occurred, and discharged large amounts of pus. After suppuration occurred the young lady improved rapidly. I am still at a loss to account for the condition, and promised that I would give the result of the case.

Dr. Painter reported a case of congenital malformation of the soft palate. Mrs. F., aged forty, a widow of eight years, consulted me on account of hoarseness following a cold. On inspecting the pharynx I found a unique anatomical relation existing between the upper part of the pharynx and the soft palate, of which the patient was ignorant. The free border of the soft palate and the palato-pharyngeus muscle on either side are carried backward and attached to the posterior wall of the pharynx, forming a diaphragm between the superior and middle divisions of the pharynx. In this dividing membrane there are two somewhat circular openings—one one half inch and the other one eighth inch in diameter. These openings are in the median line. The uvula can not be distinguished. The patient can give no reason for this marked departure from the normal construction, and was ignorant of any irregularity till I asked her to permit a demonstration of her throat to this Society. She supports a family of five by washing. She frequently has a cold in the head, but experiences no difficulty in clearing the nose. She has never had noises in her ears, and hears well. The sense of smell and taste is unimpaired, and her voice, save an occasional hoarseness, has never changed. The voice might be

described as muffled. Her sleep is undisturbed. At least two of her children have throats normal in construction. She has had typhoid fever, and believes she had diphtheria when a child. As I demonstrate the case it will be observed that she is well developed generally and in good health. In the absence of any ulcerative process, I conclude the case to be one of congenital malformation. The case has two interesting points: first, this malformation is uncommon; and, secondly, the absence of symptoms such as one would think should follow such abnormality.

Dr. Huselton reported a case of compound punctured fracture of the skull, produced by the calk of a horse's shoe. John T., aged thirty-eight, was brought into the Alleghany General Hospital on the evening of January 26th with a history of "fractured skull." He was conscious, talked rationally, pupils equal, no paralysis, and a full, slow pulse. The history, as given by himself, is as follows: He was riding in a "buckboard," leading a spirited horse by means of an ordinary halter. The horse, becoming frightened at a passing railway train, jumped upon the "buckboard," knocking the patient to the ground. He tried to rise, still holding to the strap, when the horse reared and came down, his hoof striking the patient on the head, rendering him unconscious. He did not regain consciousness for about one hour after the injury, when he walked into the hospital supported by a friend.

An examination revealed a depressed, punctured fracture of the skull, situated in the frontal bone, two inches above the right eye. The fracture was shaped like and about the size of a large almond, and very much depressed. A sero-sanguinolent fluid, supposed to be sub-arachnoid, escaped from the wound, but we were unable to find an opening in the dura mater. This fluid flowed freely as long as the head was resting on the occiput, but on turning it to either side it ceased. I trephined, removing the button from the lower portion of the wound. A number of fragments, principally from the inner table, were removed and the depressed bone elevated into position. There was no hemorrhage from the interior. The wound was flushed with a solution of bichloride of

mercury (1-4,000). A few strands of silk were placed in the opening and brought out at the lower portion of the wound for drainage. The edges were brought together by silk sutures, and the operation completed by an antiseptic dressing. On the morning of the 27th his temperature was 100.4°, but gradually and continuously dropped to 98.4° on the 29th, and remained normal from this time on. The dressings were removed on the 30th, four days after the operation. The wound had closed by primary union, and without a drop of pus or discharge of any character. The stitches and silk for drainage were removed on this occasion, and the head was redressed, observing the same antiseptic precautions as at first. These dressings were removed on February 4th; and as every part of the original injury was healed, an ordinary nightcap bandage was applied and the patient was permitted to get up on the next day, February 5th.

The case progressed without an untoward symptom of any kind. The patient was anxious to go home on the tenth day after the operation, but was kept in the hospital as a precautionary measure until February 15th, when he was discharged cured, and the opening in the skull was apparently being rapidly closed by a bony deposit. His treatment was practically nil. The diet was liquid for the first few days. A mercurial at the outset was all he had in the way of medication.

Dr. Buchanan: I would like to say a few words on the subject of trephining. I think that Dr. Huselton had very distinct indications for his operation, and it certainly was very successful. I think there are one or two points on the subject of trephining that may be dwelt on. The principal one is that the indications for trephining have entirely changed in the last few years. Formerly there was a very great difference made between simple and compound fractures. Compound fractures were recommended to be trephined that would not have been considered proper subjects for trephining had they been simple. The presence of a simple depressed fracture, if the depression is slight, it is impossible to make out. A case of depressed fracture occurred in my practice a week ago, in which it would have

been impossible for any one to make out the depression by external examination. On the following evening, when symptoms of compression came on, I opened the scalp and found the depression, removed a button of bone, elevated it, removed a clot of blood from beneath the bone, and put on a dressing. The patient afterward had no elevation of temperature, commenced to improve immediately, and is now practically well. The second point that I would call attention to is that the secondary results of depressed fractures are very much better appreciated now than heretofore. The deficiencies in intellect and epilepsies justify more frequent resort to the trephine and elevator in simple fractures of the skull. A case may recover and pass outside of the surgeon's sight, but still be a bad result; six months, a year, or several years after there may be a chronic inflammation of the membranes of the brain or some damage done to the brain by plastic effusion, which will result in epilepsy or other troubles. I would therefore think that Dr. Huselton, even if there had been no compound nature in this fracture, would have been perfectly justified in elevating it, and I would go even so far as to say that when a fracture of the skull is suspected, if there is even a suspicion of depression, an exploratory operation through the scalp should be undertaken, because, if there is no depression, such an operation would not hurt the patient a particle, and, if there is a depression, it is exceedingly important to know it and act accordingly.

Dr. Munn: In connection with Dr. Buchanan's remarks on trephining depressed fractures, I will take the opportunity to relate a case which I met in my practice a year ago in April: A man was thrown out of a wagon by a runaway horse, and, on being picked up, a depressed fracture was discovered on the upper posterior corner of the right parietal bone. He was taken to his home and there the propriety of an operation was spoken of, but it was declined by the friends of the patient. He passed out of my hands, went under the care of a homeopathic physician, and eventually recovered after remaining unconscious for seven days. He had had hemorrhage from the nose and the

ear. Now, after the lapse of eleven months, he presents a decidedly marked depression in the region of the injury, has double vision, slight paralysis of the right arm, slight paralysis of the right leg, has some aphasia and a slight paralysis of the left side of the trunk. I think the case to-day presents every indication for operation, but the operation was not performed at the time it should have been. Since the injury he has had two epileptic seizures, nothing of the kind ever having occurred to him before.

Dr. Huselton: I indorse every thing that has been said by Dr. Buchanan and Dr. Munn. I would also add, I think we are too apt to overlook the importance of a fracture of the skull; under modern antiseptic treatment I think trephining a comparatively safe operation; and in every case I think that where there is reason to suspect a depressed fracture of the skull the trephine is a proper precautionary measure to be resorted to.

Dr. W. P. Munn presented a specimen, obtained from a cadaver of unknown history, of entire absence of the innominate artery. At its place of origin the two common carotids arise together, then the left subclavian is given off, and last arises the right subclavian, which passes toward the right, behind the other three vessels.

Dr. Buchanan: I have a former patient present whom I wish to exhibit. His case I reported to the Society three or four months since. He is a man whose patella I wired. I have not before been able to present him to the Society. I wished to present him at that time, but, as I explained, he got out of my reach. I met him on the street sometime ago, and found that he had a very good result, and I thought I would show him to the Society. He was away from my laboring work just eight weeks.

(Patient exhibited.) You will observe that there is no separation whatever to be discovered between the fragments, and the joint movements are perfect. The limb is, to all appearances, as good as its mate.

Dr. Murdoch: Dr. Buchanan is to be congratulated on the result of this case. So far as can be told by an examination of this man's

leg the union is perfect; there seems to be a bony union between the fragments. I say seems to be, because I do not believe it is so. I very much doubt if bony union ever takes place in a fracture of the patella, owing to the fact that many specimens have been thought to be bony; but when examined after death, and the bones subjected to a process of boiling, it has been found the union was only fibrous. But if it is fibrous it is just as good as if it were bony, and just as useful, because there is no separation of the fragments, and by scarcely any other treatment could the two fragments be brought into such close apposition; but any body who knows the difficulty of treating fracture of the patella knows how difficult it is to keep them in apposition, and that if they are not kept so the patient is maimed for life. The only objection to this operation that can be raised is the danger of it; but under antiseptic precautions, where they are thoroughly carried out, it is probable that the danger will be but little. But it is a melancholy fact that, notwithstanding the perfection to which antiseptic dressings and surgery have been brought, this operation, even in the hands of the best surgeons, is frequently disastrous; that is, the cutting down on the knee-joint, freshening the edges of the bony surface, and wiring them together. When I was in New York, a year ago last spring, Dr. Sands told me of two cases that he had known where the patients had suffered amputation, and had eventually died, where this operation was attempted; and only about a month ago Dr. Stimson, at a meeting of the Academy of Medicine, in New York, stated that during the past summer he had known three cases where an operation had been done in New York, and the patients had in all three cases suffered amputation afterward, so that even in the hands of the best surgeons, and with the greatest care taken, it is a dangerous operation, and surgeons have been endeavoring to find one that is less dangerous that will accomplish the desired result. Whether they will succeed or not remains to be seen. About three or four weeks ago Dr. Stimson, after making the remarks I have stated, exhibited five cases where he had tied the patella together subcutaneously, and the

procedure seemed to me so simple and so likely to be successful that I think it should be tried, and if it succeeds it will be much simpler than this operation—and, I believe, safer. The operation is so simple that I will just show it here on the blackboard if I can. (Drawing made by the doctor on the blackboard, exhibiting the method of operating.) I tried this last Saturday on an old lady sixty years of age. I am not able to do what Dr. Buchanan has done, bring my patient here, and perhaps I never shall be able to do so. The patient is perfectly comfortable, and, so far as any body can tell, after this short treatment bids fair to have a good result. I do not bring this up to criticise Dr. Buchanan. I am very glad to have had an opportunity to see Dr. Buchanan's case, the first one, I believe, that has been operated on in our county.

Dr. Huselton: I want to congratulate Dr. Buchanan on the successful issue of his case. I had the pleasure of being present when he operated, and am glad to say that I think the operation was very carefully and skillfully performed. At the same time I do not believe the operation will ever become a popular one; I think that opening so large a joint as the knee-joint is too hazardous and attended with too much danger, particularly when we are having very good results by the old method. I have had several cases, at least three or four, in my practice, the last one occurring about two years ago, treated by the old method, and the result is every thing that could be desired. I did claim the union was bony; however, I think this is not the case, but if ligamentous or fibrous, it is almost impossible to detect the fact. I exhibited the case to at least one person here, and would be glad to present the case to the Society at some future time for their inspection.

Dr. Buchanan: I am very glad Dr. Murdoch presented this new method of treatment. I considered that method shortly after I had done this operation. It was then first brought to my notice. It occurred to me that this certainly is a much safer operation than the open method, but it is open to two theoretical objections; whether they are real objections time alone will tell. The first is, that it will

probably in a great many cases, if not the majority, be impossible to approximate the fragments exactly by this method. I should think the anterior borders of the patella, by this method, would be tilted a little backward, and that would keep the surfaces from coming together. In wiring a bone it is sometimes a difficult matter to get the surfaces exactly apposed, even when you have every thing open before you and are able to handle the parts, and of course it is very much more difficult when you are doing it subcutaneously. And the second objection that I would suppose to exist in regard to this method is, that the torn fragments of the capsule of the joint float in between the fragments. I believe it has been proposed to pass a needle in and hook these out from between the fragments. At all events I should imagine, from the case of this man, at least, that it would be very difficult to get these shreds from between the broken bones, and it is said by a number of good surgeons (Professor Macewen was the first, I believe, to state it), that this is a chief cause of non-union, or, rather, of the failure of bony union in this fracture. In regard to Dr. Huselton's results, I think he is to be congratulated. I do not think that the result which he has mentioned is otherwise than exceptional in these cases by the non-operative methods of treatment.

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### Reviews and Bibliography.

**The Psychic Life of Micro-Organisms.** A Study in Experimental Psychology. By ALFRED BINET. Translated from the French by THOMAS McCORMACK, with a preface by the author, written especially for the American edition. Cloth, 75 cents; paper, 50 cents. Chicago: The Open Court Publishing Company. 1889.

"M. Alfred Binet, the collaborator of Ribot, Féré, and one of the most eminent representatives of the French School of Psychology, has presented in the above work the most important results of recent investigations in the world of micro-organisms. The subject is a branch of comparative psychology little known, as the data of this department of natural

science lie scattered for the most part in isolated reports and publications, and no attempt has hitherto been made to collate and present them in a systematized form.

"Especial use has been made of the investigations of Balbiani, Claparède and Lachmann, Maupas, Ribot, Engelmann, Pouchet, Weber, Pfeffer, Kent, Dujardin, Gruber, Nussbaum, Bütschli, Lieberkühn. The cuts, eighteen in number, are illustrative of the movements, nutrition, digestion, nuclear phenomena, and fecundation of proto-organisms.

"The most interesting chapters are those on fecundation, which demonstrate the same instincts and vital powers to exist in infusoria as are found in animals of higher organization.

"M. Binet's researches and conclusions show, 'that psychological phenomena begin among the very lowest classes of beings; they are met with in every form of life from the simplest cell to the most complicated organism.' The author contests the theory of the distinguished English scientist, Prof. George J. Romanes, who assigns the first appearance of the various psychical and mental faculties to different stages or periods in the scale of zoölogical development. To M. Binet there is an aggregate of properties which exclusively pertain to living matter, the existence of which is seen in the lowest forms of life as well as in the highest."

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**Intubation of the Larynx.** By F. E. WAXHAM, M. D., Professor of Otology, Rhinology, and Laryngology, College of Physicians and Surgeons of Chicago, etc. Published by Charles Truax, 75 and 77 Wabash Ave., Chicago. 1888.

The operation for intubation has excited wide-spread interest. Since its advocacy by O'Dwyer many have taken advantage of the procedure to relieve stenosis of the larynx in diphtheria. Any thing that offered chances of relief in this most dreadful of all diseases in childhood was readily accepted. From a careful study of the operation, and the results gained, there is no doubt that in the hands of a few operators it has given results that warrant further study and trial. The book under review is written by one who has had a large experience with the method, and whose results are worth consideration.

He gives a history of the operation, a description of the instruments required, and minute directions for their introduction.

Out of 150 cases in which he performed intubation 41 recovered—or 27.33 per cent.

In comparing this operation with tracheotomy those advocating the operation of intubation do not take into consideration that as a rule the tube is inserted much earlier than has been the custom to perform tracheotomy, and therefore the operation shows results that under other circumstances might not be so good. A few of those who do the operation on a large number of cases show most encouraging results, while those who have performed only a few operations show results inferior to those given by tracheotomy. The operation has become an established procedure, and should be resorted to when the necessity for interference arises. Those who want to know the technique of the operation will do well to get this book.

J. M. R.

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Sixteenth Annual Report of the Secretary of the State Board of Health of the State of Michigan for the Fiscal Year ending June 30, 1888. By authority. Henry B. Baker, M. D., Secretary. 8vo, pp. 328; cloth. Lansing: Darius D. Thorp, State Printer. 1889.

The Sixteenth Regular Report of the Medical and Surgical Staff of St. Francis Hospital, Hamilton Square, Jersey City, N. J., under the charge of the Sisters of the Poor of Saint Francis for the year 1888. Jersey City: The Argus Company. 1889.

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Pulmonary Tuberculosis: Its Etiology Symptomatology and Therapeutics. By Prof. H. von Ziemssen, Director of the Medical Clinic at Munich. Translated by David J. Doherty, A. M., M. D., Instructor in the Chicago Polyclinic. 118 pp.; paper, price, 25 cents. "Physician's Leisure Library." Detroit, Mich: Geo. S. Davis. 1889.

Materia Medica and Therapeutics for Physicians and Students. By John B. Biddle, M. D., late Professor of Materia Medica and General Therapeutics in the Jefferson Medical College. Eleventh edition, revised and enlarged, with Special Reference to Therapeutics and to the Physiological Action of Medicines. By Clement Biddle, M. D., U. S. Navy, and Henry Morris, M. D. With numerous illustrations. 8vo, pp. 607; cloth, price, \$4.25. Philadelphia: P. Blakiston, Son & Co. 1889.

## Correspondence.

### LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

An interesting account has recently appeared which unmistakably supports the antiseptic treatment pure and simple as a means of curing or preventing zymotic diseases. An officer of the army medical staff gives the particulars of forty-five cases of Asiatic cholera which were treated by him with perchloride of mercury, the doses varying from .02 to .04 gram in the twenty-four hours. Although the cases were all of them pretty fully developed, and many so virulently as to be approaching collapse, only nine deaths occurred out of the whole number thus treated. The death-rate upon any given number of cholera cases is never less than 66 per 100 attacked. The foregoing treatment showed that this can be reduced to 20 per cent by the administration of the mercuric salt, and in all probability to a much lower figure when the correct doses and best methods of exhibiting the same have been determined by further inquiry. Still more marked were the effects of the chloride when employed as a preventive, since it was found that among per-

sons exposed to the chances of contracting the disease, but kept duly mercurialized, in no case did any development of cholera occur.

The number of lunatics chargeable to the unions in Lancashire at the beginning of the present year was over nine thousand. Dr. Cassidy says that in seventeen hundred cases admitted to the asylums the causes of mental disease were assigned, and that an analysis of these shows that in the great majority of instances the causes were physical and not moral. Under the former head intemperance in drink takes a leading place, and hereditary insanity the next. These conclusions are confirmed by Dr. Ley, whose contributions are unhappily not very cheerful. According to this experienced authority, the type of insanity has of late years markedly changed, and many kinds which may be termed incurable from the day of their development are more common now than formerly. Insanity associated with epilepsy, such as is met with in asylums, is nearly always incurable. The statistics of Dr. Ley's asylum show that the proportion of patients suffering from organic brain diseases among the admissions have more than doubled within the last twenty years. It appears a curious fact that the Irish peasant in his native country has a marked immunity from these fatal forms of brain disorders, but when transplanted into centers of labor and activity in Lancashire or Middlesex he is often apt to break down and acquire a form of mental disease progressive in its nature and little susceptible of cure.

Glycerin suppositories are now being tried in at least one public hospital in London. They are made by dissolving ten parts of dialyzed stearine soap in hot water, mixing the solution with ninety parts of pure glycerin, filtering in a steam filter, evaporating down to one hundred parts, and pouring into molds. They are also sometimes made with cacao butter.

Dr. Walter Fowler has had this year under his care some cases of laryngeal phthisis exhibiting, besides well-marked and characteristic tuberculous infiltration and ulceration, the remarkable distortions the epiglottis may undergo during the tuberculous process. In one case half of the epiglottis had ulcerated away, and the remainder was irregularly contracted by

tuberculous nodules. In another the remains of the epiglottis were represented by a small central tuberculous nodule springing from the base of the tongue. In another there was not much thickening visible, the ulceration having attacked the soft part of the free border of the epiglottis, and necrosed portions of the fibrocartilage projected palisade-like from the margin. In one other instance the ulceration was more superficial, attacking the laryngeal surface of the epiglottis, the free border of which presented a crenated appearance. In this case necrosis of the left arytenoid cartilage, with destruction of the crico-arytenoid articulation, was also demonstrated. Dr. Fowler draws attention to the fact that in such cases dysphagia, especially for liquids, varies in intensity according to the lesion of the epiglottis.

The following case has been attracting attention: In profuse bleeding from the apex of the left lung, in which hypodermic injections of ergotin and other commonly used remedies had failed to check the hemorrhage, which was sufficiently severe to threaten immediate death by suffocation, the hypodermic injection of  $\frac{1}{16}$  grain of atropine at once controlled the bleeding. During twenty-four hours the injection was repeated at intervals of every six hours. The medical attendant, thinking that the stoppage of the bleeding might perhaps have been accidental, omitted the treatment for twelve hours, with the result that a fresh and severe attack of hemorrhage ensued. This, however, was at once controlled by a renewal of the atropine treatment.

The first recorded case of Madelung's operation in this country has been performed by Mr. Howard Marsh. The patient, a man aged twenty-eight, was suffering from adenoid carcinoma of the lower three and a half inches of the rectum, involving the whole circumference but a small extent only of the anterior wall. This operation was performed as a preliminary to excision of the rectum. The usual incision for sigmoid colotomy was made, and the colon found without difficulty. To avoid the possibility of mistaking the opening from a twist of the bowel, a small-sized esophageal bougie was passed up the rectum into the sigmoid flexure. A loop of six inches was drawn down to an-

chor the upper end and guard against subsequent prolapse, and the bowel was divided with scissors. A few bleeding points were tied with fine catgut, and the edges of the lower opening were folded in and sutured with a continuous suture. This end was now returned to the abdominal cavity, and the upper orifice, which had been carefully held by an assistant, was sutured to the edges of the abdominal wound by interrupted sutures passing through all structures. The man had not a bad symptom, and made a very rapid recovery, getting up on the tenth day. Mr. Marsh thinks this operation applicable only to those cases in which the lower end of the rectum is involved. It is, he considers, especially suitable as a preliminary to extensive excision of the rectum.

Now that the subject of cremation is brought before the public by the obsequies of the Marquis of Ely, it may not be without interest to note the fact that Sir Henry Thompson is at work as hard as ever on his pet theme, and that he has just received from Sir James Naesmyth the munificent sum of £500 as a contribution to the funds of the society which seeks, on the grounds of public utility, to promote this reform of our method of burial.

There has just died an interesting subject of longevity—one James Conway, aged one hundred and six, who served in the English navy under Nelson. He was impressed in 1800, and after thirteen years' service was discharged. He was, it is stated by a medical man, in perfect health up to a few weeks before his death.

LONDON, April, 1889.

### CINCINNATI LETTER.

Hygiene v. Surgery in Gynecology was the subject of a paper before the Cincinnati Academy of Medicine, by Dr. Julia W. Carpenter. The paper and discussion turned almost completely on the subject of dress reform, or, as one member would have it, undress reform. It being a ladies' subject, it was made ladies' field night, and no gentleman was allowed to speak till all the fairer sex had had their say, an unusual occurrence in the Academy, though not elsewhere. Dr. Mary Osborne discussed the

faulty dress of the young girls she sees among the scholars at one of our fashionable girls' schools. They do not over-study their books as much as their dress, and they can not take advantage of many excellent gymnastic arrangements on account of impediments in their dress. Dr. Juliet M. Thorp said that woman would not be emancipated till she emancipated herself from her petticoats. She said one could not imagine how much freer one felt without this garment. How much better she could walk, especially if it was a windy day; for, if she had no petticoat, she did not have to stop at every street corner and unwind herself. Dr. Jessie T. Bogle made a few remarks, and then the subject was allowed to be desecrated by the discussion of the sterner sex. Several old bachelors—they were all there—said the evening had been one of the most profitable in their memory of the proceedings of the Academy. They had learned more this night than ever before. They were especially astonished at the statements of one of the lady members, that woman could dress herself with the use of only three garments. Some of the bloodthirsty men, in their discussion, left the domains of dress and fashion and waded into the gory questions of abdominal surgery and menstruation. The negligence of mothers to inform their growing daughters of the phenomena of menstruation was severely criticised. The discussion of the subject of abdominal surgery was very conservative, even by men who all know would rather carve a poor helpless woman than eat bear-meat. But the ladies had given the key-note to the discussion, and no man had the temerity to oppose them. Some interesting points as to the weight carried by some women about their waists were developed in the discussion. Much good can doubtless be done by these dress-reform movements to emancipate women from drugs, doctors, disease, and dress. May the good work go on.

The Cincinnati Obstetrical Society held its meeting at the residence of the president-elect, Dr. George E. Jones. A paper was read by Dr. Edwin Ricketts: subject

**The Abuse of Pessaries.** The doctor described his visit to the collection of gynecological instruments taken from the ruins of Pompeii, and his observation of the great sales of pessaries in the instrument stores in Birmingham and elsewhere. He related a case of interest, which occurred while he was in Tait's clinic at Birmingham. The subject was discussed by every member of the Society present, and was quite interesting, as one would suppose from the title. The differences of opinion in some points about pessaries, their action, effects, and position, were quite striking. The condemnation of the too frequent use of this instrument was very general and very uniform. Several gentlemen used the instrument almost never, and all used it much less often than formerly. Several interesting cases of abuse were given; one of these was a case where an old lady wore one constantly for fifteen years, and several others for long periods. It was agreed that this abuse now was confined in great part to midwives, who were in the habit of prescribing a ring for many uterine ailments about which they knew nothing. It was agreed that the point of great importance was the proper diagnosis of the case, the proper preliminary treatment, and the proper selection and fitting of the instrument, and the constant supervision of the practitioner. The retiring president, Dr. Giles S. Mitchell, made his valedictory address, taking as his subject for the scientific portion, Electricity for Menstrual Disorders.

E. S. M'KEE, M. D.

### Translations.

UNDER THE CHARGE OF I. N. BLOOM, A. B., M. D., DERMATOLOGIST TO LOUISVILLE CITY HOSPITAL, ETC.

**CALOMEL AS A DIURETIC.**—(Prof. J. G. Edgren—*Hygiea*, L. 12, p. 801, 1888.) Professor Edgren used calomel as a diuretic repeatedly and with good effect in edema and ascites from insufficiency of the heart. He did not confine himself to cases of valvular trouble, but employed it where the insufficiency was probably dependent on degenerative processes in the

heart muscles, and where there were no signs of valvular disease. In these latter cases the patients must be carefully watched, because toxic symptoms have been observed after 3 grains (0.20) have been given. If there is any portal obstruction existing, either alone or in conjunction with heart disease to which the ascites is due, calomel does not increase the diuresis, or at least not to any great extent. Edgren has very seldom observed toxic symptoms. In one case there was slight swelling of the gums and salivation; in some others diarrhea lasting several days. He has never observed any deleterious effect upon the action of the heart. In all cases digitalis had been given and found useless before the calomel was tried. The patient requires the most careful watching, so that the drug may be withdrawn at the first signs of salivation. He sums up the results obtained from the use of calomel as a diuretic as follows:

1. Calomel is a certain and quick-working diuretic in cases of cardiac dropsy.

2. In those cases where the patient is not so far gone that all treatment is hopeless, the failure of calomel to increase the diuresis when there is ascites and anasarca is an indication that the cause of the edema must be sought for elsewhere than in the heart.

**NEW REMEDIES.**—*Antipyrin, Antifebrin, and Phenacetin in Whooping-cough.* Dr. Leubuscher has tried all three in a large number of cases. Antipyrin and antifebrin seem to shorten the course of the disease if given at the very beginning; as for aborting it entirely, he has never seen such effect produced. If these two drugs are given when the disease is well advanced, their effect is almost nil. Phenacetin is entirely without effect.

**Antrophores in the Treatment of Gonorrhea.** Leubuscher used antrophores, which contained sulphate of zinc,  $\frac{1}{2}$  to 1 per cent; tannin,  $\frac{1}{2}$  to 5 per cent, and nitrate of silver,  $\frac{1}{2}$  to 2 per cent, and found that acute cases were cured with astonishing rapidity. The antrophores should be freshly prepared. He did not find any superiority in the much-vaunted thallin antrophores.

**Eugenol the Latest Local Anesthetic.** Eugenol

is the active principle of oil of cloves, and appears as a clear, dark-yellow fluid; it has been recommended lately as a local anesthetic. Leubuscher has experimented with it recently and found its effects so weak and superficial that they are practically of no value. (*Centr. Bl. f. Klin. Med.* x, 7, 1889.)

*Phenacetin as a Nervine.* Carl Schub, in his inaugural dissertation at Wuerzburg, claims, as the result of twelve observations, that phenacetin often cures migraine and headaches where antipyrin and antifebrin have failed. He does not pretend to explain its action. It is less reliable in various neuralgic affections. It was efficacious in a case of articular rheumatism. (*Schmidt's Jahrb.*, 1889—4.)

*Iodol in Internal Diseases.* Cervesato, of Padua, recommends iodol in scrofula (torpid form) where the lymphatic glands are very much enlarged. The dose varies, according to the age of the child, from 7 to 20 grains (0.50 to 1.50). It is valuable also in certain diseases of the respiratory organs, as, for instance, primary laryngeal tuberculosis, catarrhal laryngitis, bronchitis, pleuritis (dose, 15 to 45 grains, 1.0 to 3.0). Further, he uses it in inhalations and penciling. It finds its most useful application in tertiary syphilis in doses of 15 to 50 grains (1.0 to 3.5). It is easily borne, and iodide acne was observed but once in the case of a child. (*Ibid.*)

## Abstracts and Selections.

**DIET IN DIABETES MELLITUS.**—In discussing the dietetic treatment of diabetes mellitus, C. A. Goldsmith, M. D., of Methuen, Massachusetts, very pertinently observes:

"In this disease, above all others, we must keep our patient upon an absolutely animal albuminous diet until entire absence of sugar in the urine has been observed for at least two months. Examine urine twice a day, if practicable. Keep a record for future reference. If only a single test is made daily, it should be near midday to properly observe the effect of the previous day's diet upon the glycogenic functions.

"In enforcing this strictly dietetic régime, I can not insist too strongly upon its inviolability, for a single infraction of it, to the extent of only two or three mouthfuls, I have

seen followed by the reappearance and continuance for weeks of the dreaded sugar.

"Make your selections from beef, veal, or mutton, denuded of all fats and cartilage. Boil, stew, or broil your meats with very little butter, flavor with pepper and small amount of salt, as this tends to increase thirst and aggravate the already parched conditions of the mucous membranes. All kinds of fish, oysters, game, and fowl are also admissible. The whites of eggs may be served with light wines or lightly boiled. In cooking the fish or oysters they should never be rolled in pulverized crackers, flour, or cornmeal, as these articles are amylaceous in character, but boiled or fried with very little butter and seasoning. To combat the dyspeptic symptoms and fainting sensations which may appear by a rigid adherence to an animal diet, I have found a highly albuminous fluid food called Bovinine to act admirably. Administered a short time before meals, the patient is enabled to eat heartily with no discomfiture afterward. This article may also be used to supplement the table diet any time during the day or before retiring, as a diabetic patient should not be confined to three meals a day. During this time I would interdict the use of all vegetables and return to them with the greatest caution, using at first only those which contain absolutely no starch. This régime may appear very radical, but with the hearty and intelligent co-operation of the patient it is possible and practicable, and in uncomplicated cases I have seen it followed by the happiest results. *Cleveland Medical Gazette.*

**A CASE OF HIP DISEASE TREATED BY TREPHINING THE FEMUR.**—(Reported by George L. Kingsley, Harvard Medical School.) The patient, J. H., three and one half years old, first came under the writer's observation on July 10, 1888, when he was admitted to the House of the Good Samaritan for treatment. The family history was negative; no exanthemata or previous illness; breast-fed; began to walk at eleven months. It was ascertained that in January, 1887, he had fallen on the floor, striking on his knees. For two weeks he walked very lame, and during this time was unable to lie on his left side on account of the pain. He was taken to the Massachusetts General Hospital, where rest in bed was prescribed, and after two weeks' quiet he seemed to recover almost entirely from his lameness, but still tired easily on walking, and after going a short distance the lameness would recur. On June 27, 1887, he was treated at the Children's Hospital as an out-patient. The

hospital records show that at this time there was slight fullness over the trochanter major, which was somewhat thickened. He walked with a slight limp, and, when picking up objects from the floor, kept his left leg straight and fixed. Appetite good; bowels regular; occasional incontinence of urine. He was fitted with a Taylor hip-splint and told to return for observation, but failed to again appear until July 9, 1888, when his hip was in such bad condition that he was referred to the House of the Good Samaritan for admission. In January, 1888, the hip became suddenly stiff. He was then treated for two months by an irregular practitioner, and continually grew worse till, in March, he was unable to walk. At the time of admission physical examination showed a well-developed, well-nourished boy; the left hip flexed at forty-five degrees, and considerably abducted; the hip very sensitive and hot; skin of leg eczematous; splint very poorly applied; sinus on outer aspect of hip discharging slightly. He was placed in bed on a Bradford frame with extension. He was very fretful, and cried out at night considerably.

On July 26th, the flexion having been overcome, a Taylor hip-splint was applied, with which the patient sat up daily. On August 16th, the hip being very sensitive, and the discharge from the sinus quite profuse, he was again put in bed on a frame with extension. On September 9th, the hip having become much less sensitive, the splint was again applied and he was able to walk with crutches. October 13th he was discharged much improved, the sinus nearly closed. November 1st he returned in very poor condition; the hip very sensitive and somewhat swollen; extensive excoriations on the leg from scratching, and the splint in very poor position. He was placed in bed on a frame with extension and an ice-bag applied to the hip. He complained continually of pain in the hip, which remained quite swollen and sensitive. He had night-cries continually. The discharge from the sinus in the hip continued, but less copiously. His condition growing continually worse, it was decided to trephine the femur, and on December 10th Dr. R. W. Lovett performed the operation under ether. An incision about three inches in length was made directly over the trochanter major and the intervening tissues separated. With a quarter of an inch trephine a hole was bored, starting at a point a little below the trochanter major and passing into the interior of the neck of the femur. The tro-

chanter major and surrounding bone was found rather soft and cheesy. The core removed by the trephine was about one inch long, the inner end rather soft and dark-colored. A curette was inserted and a considerable amount of a soft, cheesy material, quite dark in color, removed, the cavity in the neck and head of the femur being scraped clean. The cavity was thoroughly irrigated with 1-3,000 corrosive-sublimate solution, a rubber drainage-tube inserted, extending to the bottom, the incision sewed up, and the whole dressed antiseptically. He passed a very comfortable day and night, and seemed to have little pain. The following day his general condition was very good, little pain; morning temperature, 101°, and evening, 103°. During the night he cried out a few times, and the next day was somewhat restless; morning temperature, 101°, and evening, 104.5°. The patient looked rather feverish, but was quiet. During the night he cried out a few times. The next day his general condition was better; morning temperature, 101°, and evening, 102.5°. The dressing was removed, the drainage-tube found to be plugged with the discharge, and, having been cleaned out, was reinserted, and the wound dressed as before. From this time the convalescence was uninterrupted, the night-cries gradually subsided, and after January 24th they ceased entirely. The drainage-tube had to be removed and cleaned several times, and on January 14th it was omitted, the incision having entirely healed except where tube had been inserted.

January 16th the patient began to sit up, and on the 21st was able to walk on crutches. On February 11th he was sent to the Convalescent Home at Arlington, the wound being closed except at one point, from which there was a slight discharge. He has improved steadily since his arrival at Arlington, and is now able to bear his weight on left leg without causing any pain.—*Boston Med. and Surg. Journal.*

THE COMPARATIVE VALUE OF THE DIFFERENT METHODS OF TREATING ACUTE GONORRHEA.—Under this somewhat misleading head, Dr. André Martin, physician-major, publishes an interesting article in the *Journal de Médecine*, in which he contrasts what he calls the old with what he calls the modern methods of treating acute blennorrhagia.

The old or classic treatment begins at a date more or less remote from the onset of the disease, respects the period called in-

flammatory, and is directed to the stationary period (*période d'état*) and period of decline; it is both general and local, including, with rest and dieting, the balsams (copaiba, gurjun, sandal) alone or combined with injections; the latter are astringent (sulphate of zinc, acetate of lead), or simply protective, like bismuth and silicate of potash. All these injections have been accused of causing stricture, but the French writer declares it as his conviction that the duration of the flow more than the nature of the treatment contributes to the formation of consecutive strictures.

In a first series of clinical experiments Martin, following the precepts of Fournier, treated all the patients of his army corps for a fortnight to local and general baths, to emollient, mucilaginous drinks, to bicarbonate of soda, etc.; and it was not till during, or at the end of the third week, when the discharge and micturition were without pain, that he began the use of copaiba, alone or associated with cubebs, and injections of sulphate of zinc, one grain to the fluid ounce, from one to five injections a day, in an increasing ratio up to five injections, then in a decreasing ratio back to one injection a day. During the stationary period, the zinc injections are well borne, and seem to favor the action of the balsams; the latter were not always prescribed, but in all cases a mild and cooling dietetic regimen and the use of emollient drinks preceded the employment of the injections. The following are the statistical results of this method. The average duration of the treatment is based on the number of days spent at the infirmary or hospital:

Number of cases of blenorrhagic urethritis.....	62
Days of treatment.....	1684
Average duration.....	27.16

These figures agree to the fraction of a unit with the statistics of the Arzew hospital, which, out of one hundred and thirty cases, give the average duration as 27.26 days. Since 1884 Martin has invariably had recourse to antiseptic agents in the treatment of acute blennorrhagia. He makes use of the three following formulæ, the preference being given to the  $\frac{1}{20000}$  solution of bichloride of mercury:

- A. Sulphate of quinine..... 1 part;  
Glycerine ..... 25 parts;  
Distilled water..... 75 "  
Acid sulphuric, q. s. to dissolve.

The above is a one-per-cent solution.

- B. Van Swieten's solution of  
bichloride of mercury.. 10 parts;  
Distilled water..... 190 "

The above is a very weak solution of the bichloride, 1 to 20,000.

- C. Perm'nate of potash. 0.05 (1 grain);  
Distilled water.... 100.00 (5ij-5jss.)

The treatment is begun the day when the patient first presents himself at the hospital for treatment; that is, generally from the second to the sixth day after the commencement of the discharge. Three injections a day are made, three syringefuls at a time. The injections are tepid, and tepid fomentations are kept continuously upon the penis. The injections are made with great gentleness. When the flow begins to dry up, the number of injections is decreased, till finally but one injection a day is made. The patient is kept in the hospital one week after cessation of all treatment, and is not discharged till he is believed to be absolutely well.

The following table gives the results of treatment by antiseptic injections:

AGENTS EMPLOYED.	CASES TREATED.	DAYS OF TREATMENT.	AVERAGE DURATION.
Sulphate of quinine (1 per cent solution).....	10	296	29.6
Pernanganate of potash (1 per cent solution).....	47	1281	27.25
Bichloride of mercury (1 per 20,000 solution).....	45	953	21.17
Total .....	102	2530	24.71

From the above, it will be seen that we have an average duration of 24.71 days, as contrasted with 27.16, where the treatment was according to the older "classic" methods. It will be seen too, that, of all the agents employed, the sublimate injections gave the best results, the average duration of the disease, when treated by this antiseptic, being 21.17.

Antiseptic injections can hardly be said to constitute a "new treatment" of acute blennorrhagia, except in the fact of their application from the very commencement of the disease, and to the exclusion of all other treatment. It is surprising to see how little pain they occasion, even during the so-called inflammatory period, and they seem to produce rapid amelioration in the intensity and nature of the discharge. According to Martin, this treatment is much less liable to be attended with complications, such as orchitis, cystitis, prostatitis, than the ordinary treatment, and he presents statistics to prove his affirmation.

During the antiseptic treatment no special care about diet seems necessary. Sometimes full doses of bromide of potassium (sixty to ninety grains) prove a useful adjuvant, especially in cases of "exaggerated erethism;" an occasional injection of one sixth of a grain of morphine in the lumbar region may be indicated. In cases complicated with chordee, lavements or suppositories containing fifteen grains of chloral sometimes give excellent results.

In cases complicated with cystitis, orchitis, or prostatitis, the microbicide injections are to be suspended to give place to emollients and sedatives.

It is worthy of remark that the results of the germicide treatment, as given by Martin, are much inferior to those claimed by some other authorities, notably Bourgeois, Chameron, and Constantin Paul.

The conclusion that patients are perfectly well at the time of discharge from hospital in these cases deserves notice. Nothing is stated in the article to show that any unusual care is taken which would warrant such a conclusion. There is nothing to show that in these patients a thin, transparent, gleety discharge does not appear as in other patients a short time after their return to duty. It is not easy to determine that a given patient is actually cured of gonorrhea. The optimistic views of Dr. Martin need to be balanced by more philosophical and scientific views, such as those advanced by Drs. Bryson and Burnett in the *Journal of Cutaneous and Genito-urinary Diseases*. These authors confirm the previous observation that the gonococcus of Neisser persists in some cases after all discharge has ceased, and thus acute symptoms may be lighted up by any undue excitement.—*Boston Medical and Surgical Journal*.

**ACETYL-PHENYL-HYDRAZIN AS AN ANTI-PYRETIC.**—Not long ago another new antipyretic, with another barbarous name, was offered for clinical tests. The first reports were somewhat favorable, but later experiences were the reverse of favorable, toxic action and a tendency to collapse, similar to that following the administration of kairin, being observed. These drawbacks are since said to have been due to impurities or accessory products in the drug as administered. A pure preparation is now promised of this new antipyretic, known as acetyl-phenyl-hydrazin; its chemical formula— $C_6H_5NH.N.H.CH_2CO$ —shows a marked relation to that of antifebrin— $C_6H_5NH.CH_2CO$ —

differing from it only by the increment of one imido-group (NH).

We learn further, in regard to this new contestant for antipyretic honors, that its derivative composition—from phenyl-hydrazine, with an acetic-acid rest—relates it likewise to antithermin— $C_6H_5NH.N([C.CH_3][CH_2.CH_2.COOH])$ —which is produced by the dehydration of a combination of phenyl-hydrazine with levulinic (beta-aceto-propionic) acid, a higher homologue of acet-acetic acid. Equally, the derivation of antipyrine (phenyl-dimethyl-pyrazolone)— $C_6H_5N([N.CH_3][C.CH_3].CH.CO)$ —from a phenyl-hydrazine compound with acet-acetic ester, places that substance in relation with the subject of this article; and the analogy between antifebrin, mentioned above, and its kin-compound phenacetin— $C_6H_4(OC_2H_5)NH.CH_2CO$  (differing by the substitution of an oxyethyl group  $[OC_2H_5]$  for a hydrogen atom)—brings the latter-named antipyretic also into the line of these chemically and therapeutically inter-related compounds.

From the foregoing the conclusion is suggested that the claim of acetyl-phenyl-hydrazin, as a legitimate member of this extended antipyretic family, to an exact clinical test of its powers, when employed pure! rests on good presumptive evidence.

It is not amiss to encourage judicious clinical tests of these new antipyretics as fast as they are presented with reasonable claims to attention as being improvements on their predecessors.—*Ibid*.

**TREATMENT OF TETANUS BY ABSOLUTE REST.**—Prof. de Renzi, of Naples, has carried out the treatment of tetanus by absolute rest in four cases, and has obtained a successful result. He was led to try the treatment through noticing that a frog poisoned with  $\frac{1}{20}$  milligram of strychnia and exposed to the influence of light and sounds could not be saved; but if it were kept in absolute rest it survived.

The following is the treatment adopted: The patient's ears are stopped with wax and cotton, and he is brought into a very quiet and dark room, into which no noise is allowed to penetrate. It is impressed upon the patient that his recovery depends upon absolute quiet. The room is entered only every four hours, and with a dark lantern. Nourishment is fluid, and is given by the mouth, so that chewing will be avoided. When there is marked pain some belladonna and ergot is given. Of five patients so treated, four recovered.—*Wiener Med. Presse*.

# The American Practitioner and News

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## SAMUEL WEISSEL GROSS.

This eminent surgeon, teacher, and author died in Philadelphia on the 16th of April. He was born in Cincinnati, February 4, 1837. He received his literary education in Shelby College, Kentucky, and studied medicine in the Medical Department of the University of Louisville and the Jefferson Medical College, graduating from the latter in 1857. He entered at once upon the practice of his profession in Philadelphia, where, as lecturer in the schools, as surgeon in the hospitals, as an original investigator in the pathological laboratory, as contributor to the medical journals, and as a writer of books, he achieved distinction second only to that of his great father.

During the civil war Dr. Gross was a brigade surgeon, with the rank of major of volunteers. At its close he was brevetted lieutenant-colonel in graceful recognition of his faithful service and superior work.

In April, 1882, on the retirement of his father, he was elected one of the professors of surgery in Jefferson Medical College. This was merely a promotion, with change of title, for Dr. Gross at that time had been for many years a lecturer on surgery in Jefferson; first, on surgical anatomy and operative surgery,

and, later, on genito-urinary diseases. It was in the lecture halls of this institution and before the College of Physicians that he became known as one of the ablest instructors in the land, and it was in preparation of these lectures that he made the original studies in pathology and genito-urinary surgery which have spread his fame abroad over the civilized world. His treatises upon genito-urinary diseases and tumors of the female breast are, in the main, original contributions to these departments of medicine, and will perpetuate his fame.

Dr. Gross was a man of fine physique and stately bearing, a commanding figure in any assembly, but modest, gentle, genial, and generous to a fault. He dies at an age when to most men death is untimely, but at an age when he could well afford to die, since future years were not needed for the achievement of name or fame in the annals of his art. To surgery, however, which, had he lived, he would have further enriched, his death is a substantial loss, while to his family, his students, and the guild who loved him, it is a hard arbitrament of fate.

## THE KENTUCKY STATE SOCIETY.

As we go to press the news comes that the State Society, now assembled at Richmond, opened with a large attendance, and with the prospect of proceedings of more than wonted interest. Our reporter is in the assembly, and our readers may look for a full record of the society's work in our next and subsequent issues.

"THE COMING MEETING OF THE AMERICAN MEDICAL EDITOR'S ASSOCIATION," says the Medical Record, "will be held at the Casino at Newport, Monday evening, prior to the opening of the American Medical Association. The editor and staff of the New England Medical Monthly, together with a few friends, will tender the Association a steamboat excursion, with plenty of water on board, and at the end of the sail a regular old-style Rhode Island clam-bake."

It is confidently stated by those who have the ordering of this meeting, that the turn at

*casino* will not, later in the evening, be suffered to degenerate into *poker*, while the Kentucky delegation will see to it that the "water on board" shall be so spiked with our local stomachic that it will be in no danger of going overboard during the voyage.

### Notes and Queries.

WHAT A PATIENT MAY DEMAND OF A HOMEOPATH.—On March 11, 1889, the N. Y. Medical Times addressed a letter to the Hon. George C. Barrett, Judge of the Supreme Court, asking him to answer the following question: "Has a physician designating himself a 'homeopathist,' and called as such to a patient, any legal or moral right to adopt other than homeopathic means in the treatment of the case?"

To this Judge Barrett replied, under date of March 13, 1889: "I have your note of the 11th inst., asking my opinion upon a question of professional ethics. In my judgment there can be but one answer to your question, and that is in the negative. If I call in a medical man who designates himself a 'homeopathic physician,' it is because I do not wish to be treated allopathically, or eclectically, or otherwise than homeopathically. There is an implied understanding between myself and the homeopathist that I shall receive the treatment which by tradition and a general consensus of opinion means small doses of a single drug administered upon the principle of '*similia similibus curantur*.' If there is to be any variation from that method, I have a right to be informed of it and to be given an opportunity to decide. Common honesty demands that, before a confiding patient is to be drugged with quinine, iron, morphine, or other medicaments, either singly or in combination, he should be told that the 'homeopathist' has failed, and that relief can only be afforded by a change of system. An honest 'homeopath' who has not succeeded, after doing his best with the appropriate homeopathic remedies administered on homeopathic principles, should undoubtedly try any thing else which he believes may save or relieve his patient. But when he reaches that point the

duty of taking the patient into his confidence becomes imperative. The patient may refuse to submit to the other system, or he may agree but prefer a physician whose life has been specially devoted to practice under that other system. He may say to the 'homeopathist,' You have failed, but I prefer to try another gentleman of your own school before resorting to a system that I have long since turned my back upon. Or he may say, Well, if homeopathy can not save me, I prefer to go to headquarters for allopathic treatment.

"All this, gentlemen, is the logical sequence of the particular designation 'homeopathist.' There may, of course, be gentlemen who in a general way favor the principle of small doses and '*similia similibus curantur*,' to whom it would not apply. But such a physician would not stamp his school upon his work as a practitioner. If I call in such a man, I mean a physician pure and simple, calling himself neither homeopathist nor allopathist, the implied understanding is that I intrust myself to his best judgment in all respects. Such a man may be a graduate of the College of Physicians and Surgeons, and I will have no cause of complaint should he in an exigency deem it appropriate to administer the third potency of *acónite*. Or he may be a graduate of a college founded under homeopathic auspices, and yet I can not object if he thinks the occasion demands twenty grains of quinine. But if a physician calls himself allopathic and is summoned as such, it would be a fraud to resort to homeopathic treatment without full disclosure to the patient of what was proposed. If, however, we are to have a class of men who purpose, in the interest of humanity, to utilize the best that they can find in any and every school, 'pathist,' as a designation of fixed methods of practice, must be ignored, and the broad and noble title 'physician,' in its unreserved sense, be revived and substituted.

"The patient will understand, when he sends for one of this class, that he is to have the physician's best judgment in the unprejudiced use of the ripest fruits of modern discovery in every field. I see that I have done more than simply answer your question. But I am sure you will pardon a layman for taking advantage

of the occasion to intimate the need of greater clearness of professional attitude, both as a matter of justice to the patient and as due to the integrity of the physician."

**EXECUTION BY ELECTRICITY.**—Before the New York Act directing that the death sentence shall in future be carried out by submitting the convict to a discharge of electricity could be enforced, it was necessary, that the experiments should be repeated before the officials of the prison's service. After the rapid and painless character of the death had been demonstrated on dogs, four calves, each weighing about as much as a man, were killed, a current of 800 volts being used for fifteen seconds. Finally a horse, weighing 800 pounds, was killed by a current of 1,000 volts, applied for fifteen seconds. All the animals, it is stated, died instantaneously, without pain or struggle. Bills drafted on the same lines as the New York Act are now, it is said, before the legislatures of Alabama, Illinois, Ohio, and Missouri.

**CLINICAL SIGNIFICANCE OF COLORLESS STOOLS AND THE RELATION OF CERTAIN CASES WITH DISEASE OF THE PANCREAS, ETC.** No fact in medicine is more certain than that obstruction to the entrance of bile into the intestines will cause colorless stools; the vast majority of cases of clay-colored or colorless stools depend on such obstruction, and such cases require no fresh explanation, for the brown coloring matter of the feces certainly results from the changes which the bile undergoes in its passage through the intestinal canal; and, granting this, there can be no brown coloring matter if there is no bile. But my cases prove, what was unknown before, that the presence of the pancreatic juice is essential to these changes in the bile which lead to the production of the brown excrement, and that this brown excrement will not appear if the pancreatic duct be obstructed, or if from any other cause there is an absence of pancreatic fluid in the intestines. This is a new clinical and physiological fact, which can be accepted without the adoption of any opinion as to

the chemical changes which take place. If a man with an obstructed common bile-duct takes an aperient dose of sulphate of soda, he will pass only a loose colorless motion: if a healthy man takes the same dose, he will pass a loose motion charged with an excess of the brown coloring matter, which is a product of the digestion of bile; but in neither of the cases of obstructed pancreatic duct with healthy liver and patent bile-ducts does this or any other aperient ever produce other than a colorless stool, and I can see no other conclusion than that which I draw, viz., that the more of this brown matter which appears in the feces the less of the digested bile has been absorbed from the intestines, and that if the brown matter can not be formed without the aid of the pancreatic juice, the pancreas plays an important part in determining the amount of the digested bile which shall be absorbed from the intestines and the amount which shall be eliminated in the form of brown excrement.  
*Dr. Thomas J. Walker, London Lancet.*

**A HINT FOR FACILITATING THE MICROSCOPICAL EXAMINATION OF URINE.**—When attempting to examine urine under the microscope for casts, epithelial cells, and other organic bodies, a good deal of annoyance and difficulty is sometimes caused both by urates and, also, when the specimen is not quite fresh, by fermentation and putrefactive products. In order to obviate this difficulty, and with the further view of preserving the specimen, Dr. M. Wendringer advises that the urine should be mixed with a nearly saturated solution of borax and boracic acid. This dissolves the urates and keeps the urine from fermenting, and at the same time exercises no destructive effect upon the casts and epithelial elements which it is desired to examine. The solution is prepared by mixing twelve parts of powdered borax in one hundred parts of hot water, and then adding a similar quantity of boracic acid, stirring the mixture well. It is filtered while hot. On long standing a small deposit crystallizes out, but clings to the side of the vessel, so that it does not interfere with the

transparency of the liquid. The urine to be examined is put into a conical glass, and from a fifth to a third of its bulk of the boracic solution added to it and agitated with it. The urine will be found to become clear in a short time—that is, if there is no cloudiness due to bacteria—and it will remain unchanged for several days. If it is only wanted to clear the urine and to make it keep for a day or two, the addition of a smaller quantity of the boracic solution is sufficient. If a third of its bulk is added, no fermentation or putrefactive processes take place, even if the glass is left uncovered in warm places. Albumen, too, if it exist, is not coagulated. The organic elements, as epithelial cells, casts, blood corpuscles, etc., collect so quickly, without undergoing any morphological change, at the bottom of the glass, that the first drop taken up by the pipette usually proves a satisfactory specimen.—*Ibid.*

**DEATH AFTER IMMERSION IN WATER.**—The death of Castel, the unfortunate valet of Prince Jerome Bonaparte, after he was rescued from the waves during the loss of the Comtesse de Flandres, will serve to remind the public of a fact sometimes overlooked. The victim, when actually pulled out of water alive, is by no means necessarily safe. Castel was elderly, having been in the service of Prince Jerome for forty-three years. Simple exhaustion probably proved fatal. Dr. Ziegler pointed out, some time ago, that a deep-red coloration of the skin, when it occurs in an exhausted bather, is a sure foreteller of coming syncope. In cases of accidents at sea several conditions may be present which may prove fatal to a half-drowned man, or which may cause a very short subsequent immersion to kill the victim. In collisions the sufferers are subjected to shock and fright before they sink. In this special instance there was also a boiler explosion. There is always danger from blows from falling spars, from the keels of boats sent to rescue, and from rough hauling on to the deck of the craft which keeps afloat. Simple prolonged immersion, nevertheless, might have killed Castel. A man used to face

danger may recover from shock before immersion during a collision at sea, but the latter condition must involve the entrance of much sea-water into the lungs as he grows exhausted and sinks. If pulled up, his heart, weak from exhaustion, and his lungs, irritated by the water, may not be in a condition to maintain life. The subject is not without interest; few forms of sudden death appear more simple to explain than death from drowning or prolonged immersion, yet it is doubtful if any be more complex.—*British Medical Journal.*

**VACCINATION.**—The Bristol Medico-Chirurgical Journal, reviewing some books on Vaccination, says: Vaccination has got into undeserved discredit by the way in which its details have been carried out by thoughtless or careless operators. It is much to be desired that all vaccinations should be taken out of the hands of private practitioners and allowed to be performed only by public vaccinators. The difficulties in the way of this much-needed reform could be easily overcome. Vaccination, as an important branch of preventive medicine, should be under government inspection. Not only is there great difficulty, privately, in obtaining trustworthy lymph, often necessitating a resort to unauthorized sources, but, in deference to the sentimental objections of ill-informed parents, there are many practitioners of good social standing who are not ashamed, by vaccinating by one or two small insertions, to earn a cheap popularity, although thereby a serious danger is added to the life of a child thus made unfit to successfully resist a possible attack of smallpox. There are also doctors of a lower grade who set themselves up in unwholesome opposition to the public vaccinator, and, by performing the operation for a degrading fee of sixpence or a shilling, with a vaccination also much reduced in quantity, and therefore in quality, draw off a considerable number of ignorant mothers from the vaccination station, the efficiency of which becomes impaired through a greatly diminished attendance, seriously limiting the selection of lymph, the proper

management of which becomes well-nigh impossible.

In the light of Marson's figures (Seaton's *Handbook of Vaccination*, ed. 1868, p. 216; McVail, p. 36; Woodward, p. 15), confirmed by all after-experience, conduct such as this in various walks of professional life, seems little short of criminal, and has now reached such appalling magnitude as to urgently call for government interference.

If vaccination is to be a reality, and not merely something which leads its subjects into a fool's paradise, the State must insure, by an inspection through properly qualified officials, that it is carried out in all ranks of society in a thoroughly efficient manner.

**A CASE OF ANTIPYRIN-POISONING.**—Dr. W. P. Northrup reports a singular case of antipyrin-poisoning, showing extreme susceptibility to this drug. (*Medical News*, April 27th.) The first specimen was subsequently tested clinically and seemed to be good, and the second specimen was selected with especial care. The symptoms observed are briefly recapitulated at the conclusion of a detailed description, as follows: Fifteen grains of antipyrin caused, in an hysterical woman, sneezing, evacuation of the bowels, syncope (thirty minutes), vomiting, prostration. Five grains caused sneezing, urticaria, and diffuse hyperemia of the skin, dyspnea.

**AMERICAN MEDICAL ASSOCIATION. FORTIETH ANNUAL MEETING.**—The officers of the Section of Laryngology and Otology can assure the profession of a full and profitable session, as there have already been promised over thirty papers. The following is but a partial list of the contributors. A revised list will be published soon:

Bryson Delavan, M. D., C. H. Knight, M. D., Lawrence Trumbull, M. D., Holbrook Curtis, M. D., Charles H. Knight, M. D., C. E. Bean, M. D., George A. Richards, M. D., Charles Denison, M. D., S. S. Bishop, M. D., A. B. Thrasher, M. D., Carl Seiler, M. D., Charles E. Sajous, M. D., Hal Foster, M. D., John E. Logan, M. D.,

F. Whitehall Hinkel, M. D., W. C. Richardson, M. D., F. O. Stockton, M. D., Lenox Browne, London.

The following have signified their intention of furnishing papers, if possible for them to do so:

E. F. Shurley, M. D., E. Holden, M. D., J. N. Mackenzie, M. D., John Porter, M. D.

The programme will be carefully arranged and a definite time allowed for each paper, so that no time need be wasted. All titles should be sent to the secretary, E. Fletcher Ingals, M. D., 70 State Street, Chicago, before the 14th day of May.

W. H. DALY, M. D.,

*President.*

The following additional papers have been prepared for the Section on State Medicine:

"Notes on the Progress of Leprosy," Dr. Benjamin Lee, Philadelphia, Pa.

"Disposal of House Refuse," Dr. Alfred L. Carroll, New York, N. Y.

"Modern Sanitary Conditions," George E. Waring, jr., Newport, R. I.

"Ranch Life in Texas for Consumptives," Dr. J. R. Briggs, Dallas, Texas.

"The Benefits of Sanitation Applied to Obstetric and Gynecological Surgery," Dr. T. A. Ashby, Baltimore, Md.

"Report of the Standing Committee on Meteorological Conditions," Dr. N. S. Davis, Chairman.

S. T. Armstrong, United States Marine Hospital Service, New York, is secretary of this Section and J. Berrien Lindsley is chairman.

"DOES THE USE OF ALCOHOL SHORTEN LIFE?"—The paper on the question, "Does the Use of Alcohol Shorten Life?" by Mr. James Whyte, Secretary of the United Kingdom Alliance, has been called forth by the misrepresentations and misunderstandings of certain portions of the Collective Investigation Report on Habits of Intemperance. When the returns of the temperance inquiry were made up, it was found that the average age at death of the total abstainers reported on was remarkably low—lower, indeed, than that of any class of users of alco-

hol. Dr. Isambard Owen, who prepared the report, took some trouble to demonstrate the fallacy that would underlie a *prima facie* interpretation of this fact, which he showed to depend, in a large degree at least, upon the comparative youthfulness of the teetotal body, and he summed up by saying that no comparison between the longevity of total abstainers and that of other classes could be obtained from the figures in question. By dint, however, of quoting the figures and omitting the equally important context, some spokesmen of the liquor-selling interest have claimed to assure the public "on medical authority" that total abstinence has been proved to be a practice highly detrimental to health, and that abstainers are a shorter-lived body of men even than habitual drunkards. The doctrine thus baldly presented is fortunately preposterous enough to defeat its own object, but none the less is it well that its falsity should be pointed out in detail, as Mr. Whyte has done. Mr. Whyte, however, does not merely stand on the defensive; he has carried the war energetically into the enemy's camp, and compiled from the published statistics of insurance and friendly societies a formidable body of evidence in favor of the superior healthfulness of abstainers as compared with the non-abstaining general public. These statistics are not now presented for the first time, but they are placed before the reader in a very cogent manner, and are well worth the attention of every practicing medical man whose daily responsibility it may be to advise his patients as to the use or disuse of alcoholic liquors. We will not go so far as to say that they are sufficient to settle the whole question of abstinence *versus* alcohol. The comparison they enable us to make is between the death-rate of teetotalers and that of a somewhat miscellaneous class of drinkers; but the exact effect upon health, for good or for ill, of such small daily quantities of alcohol as Dr. Parkes, for instance, regarded as non-toxic, we have no present means of gauging. The question, perhaps, is one of more importance to pure pathology than to medical practice. Enough evidence

is before us to convince any reasonable man that the detriment to health, if any, produced by abstinence from alcohol is minute in comparison with that due to even moderate excess in its use, and that the cases are exceptional in which the practical physician need insist on alcoholic liquors as an article of general diet, or hesitate to recommend the disuse of them, if on other than medical grounds it should seem advisable to do so. *London Lancet.*

**YELLOW FEVER.**—A pretty well authenticated case of yellow fever has been reported at Sanford, one hundred and twenty miles south of Jacksonville, Florida, that terminated fatally on the 20th of April, 1889. The victim was a Mrs. Dumont, the wife of a baker and keeper of a boarding-house. Active measures are being taken to prevent its spread, under the direction of Dr. Daniel, President of the Florida State Board of Health. The sanitary condition of Jacksonville is reported as good.

**MR. STANLEY ON ARROW POISON.**—The letter from Mr. H. M. Stanley, which was read at the meeting of the Royal Geographical Society on Monday last, contained an extremely interesting reference to the arrow-poison employed by the natives of the Lower Congo district, and it afforded a curious insight into the strange perversions of knowledge by which the advances of civilization are retarded. Mr. Stanley says they were much exercised as to what might be the poison on the heads of the arrows by which Lieutenant Stairs and several others were wounded, and from the effects of which four persons died almost directly. The mystery was solved by finding at Arisibba several packets of dried red ants. The bodies of these insects were dried, ground into powder, cooked in palm oil, and smeared on the points of arrows. It is well known that formic acid exists in the free state in red ants, as well as in stinging nettles, and in several species of caterpillars. This acid is, in the pure state, so corrosive that it produces blisters on the skin, and hence there

is little ground for doubting that it was the "deadly irritant by which so many men had been lost with such terrible suffering." The multitude of curious insects encountered, which rendered their lives "as miserable as they could well be," bears out Mr. Stanley's idea that many similar poisons could be prepared from insects. It certainly is strange that, with the exception of cantharides, and perhaps of *blatta orientalis*, the insect world is so little used for active therapeutics.—*London Lancet*.

**THE SYMBOL Oss.**—At a recent meeting of the Midland Counties Chemical Association a member stated that there was some doubt as to the meaning of the symbol *Oss*; twenty-eight replies to an inquiry had been received from medical practitioners; twelve understood the symbol to mean eight ounces, and sixteen ten ounces. The president of the Association has in consequence addressed a letter to the General Medical Council urging it "to take such action as will relieve pharmacists from the serious difficulty under which they are now unavoidably placed." There ought, however, to be no difficulty in the matter, and the General Medical Council has already, so far as is in its power, removed all ambiguity by distinctly stating that one pint contains twenty fluid ounces, and that the symbol for it is *O*.—*British Medical Journal*.

**CARBOLIC ACID AND IODINE IN WHOOPING-COUGH.**—Dr. Rothe, having met with some unfortunate cases of whooping-cough treated with antipyrin, turned his attention to a combination of iodine with carbolic acid in the treatment of this affection, and with this combination he has obtained excellent results. He has, he says, treated hundreds of cases, and can not remember one in which the affection lasted longer than four weeks, besides which no fatal case occurred. The mixture he employs is as follows: acid. carbol., 15 gr.; sp. vin., 15 gr.; tinct. iod., 10 gtt.; tinct. bellad., 30 gr.; aq. menth. pip., 2 oz.; syr. opiat., 150 gr. A teaspoonful of this is given to children over two years of age every two hours. When this treatment was carried out

from the commencement of the complaint the severity was never great, and even when it was only begun in cases that had been going on for six or seven weeks it soon cut them short.—*London Lancet*.

**THE MICROSCOPE.**—The three hundredth anniversary of the invention of the microscope will be celebrated by the Executive Committee of the International Exhibition of Geographical, Commercial, and Industrial Botany at Antwerp in 1890. A retrospective exhibition will be got together from all available quarters, illustrating the history of the microscope, as well as an exhibition of the modern instruments of existing makers. A variety of conferences relating to technical and scientific questions connected with the microscope will be arranged. Already great interest is being expressed in the proposed exhibition.—*Maryland Med. Journal*.

**THE LATE DR. VON LAUER.**—The death is announced, from Berlin, of General Staff-surgeon von Lauer, who from the year 1844 till his death acted as the trusted body physician of the late Emperor William, and attended him in his last hours. The Emperor William I, the Emperor Frederick, and the present Emperor each bestowed upon him many marks of the esteem in which he was held, not only by his imperial masters but by all his fellow-countrymen.

The third obstetric clinic at the Vienna Hospital, the director of which is Dr. G. Braun, has had to be closed on account of the occurrence of an epidemic of puerperal fever. This is believed to be due, not to any want of antiseptic precautions, but to the unsatisfactory hygienic condition of the building, which is old, and in which there have been repeated epidemics of puerperal fever.

**A THING THAT CAN NOT BE SOLD.**—The French courts have decided that a physician can not legally sell his practice, on the ground that a medical practice is not an article of commerce. A contract to abstain from practicing in any given neighborhood is, however, valid, and to be capable of enforcement at law.

**A CHALLENGE TO YELLOW JACK.**—It is announced that Mr. John G. Borden, a winter resident of Florida, has offered a prize of \$1,000 to the city within that State that shall be found in the most cleanly condition on the 1st of July. From the reports received the cities in that region are not in a clean condition, and no steps are taken to make them so. It is to be hoped that the judges of cleanliness will come from clean cities, and absolute, not relative or comparative cleanliness will be the basis of awarding the prize.—*Maryland Medical Journal*.

**PICRIC-ACID APPLICATIONS IN ERYSIPELAS.** A solution of picric acid in water, of the strength of 6-1,000, is strongly recommended by Dr. Calvelli as an external application in erysipelas, whether of a slight or of a severe character. In cases where the prostration has been considerable, together with delirium and a high temperature, painting the affected part with the solution from five to ten times a day very soon brought down the swelling in the cellular tissue and reduced the fever. The same treatment is recommended in cases of lymphangitis and eczema.—*London Lancet*.

**ANEMIC.**—According to the British Medical Journal, official statistics show that there are only 118 homeopaths in Austria out of the whole number of medical men, 7,183, and that only 44 of those profess to practice homeopathy exclusively. There are none at all in the Italian districts, and but 19 in Vienna. They are said, too, to be decreasing in number.

THE Health Commissioner of Baltimore was notified, April 23d, that at Santos and Rio, the ports from which the coffee importers of Baltimore receive nearly all their coffee, the yellow fever is raging more virulently than ever before. At the time of the last report from Rio there had been one hundred and eighty-six deaths from yellow fever in four days.

THE Iowa State Medical Society will meet this year at Keokuk on May 15th, and will continue in session three days. President, Donald Macrae, M. D.; Secretary, S. S. Lytle, M. D.

THE Medical Record says that in a London hospital a woman, sixty-eight years of age, with scirrhus cancer of both breasts, had them both removed simultaneously by two surgeons, one on each side of the table. The whole operation lasted forty-five minutes, and after a short time she was discharged well.

THE family of the late George L. Harrison, of Philadelphia, has offered \$200,000 to the Board of Trustees of the Protestant Episcopal Hospital, with which to found and endow a building for incurables. The Board will accept the offer. Mrs. Harrison joins with her four sons in making the gift.

THE ST. LOUIS POLYCLINIC, the organ of the St. Louis Polyclinic, a monthly journal, has made its appearance. It is edited by Dr. L. A. Turnbull. The initial number is replete with interesting matter.

THE AMERICAN SURGICAL ASSOCIATION will hold its next annual meeting in Washington, May 14, 15, and 16, 1889. David W. Cheever, M. D., of Boston, President, and J. R. Weist, M. D., Richmond, Ind., Secretary.

THE British public need be in no fear of a short supply of medical men. The fear must be the other way, of a short supply of patients, and may well make young men ponder who have not yet committed themselves to the profession.—*London Lancet*.

THE president of the Board of Health of Sanford, Florida, stated, April 23d, that a case of yellow fever existed in that city. Every precaution has been taken to prevent a spread of the disease.

MICHEL EUGENE CHEVREUL, the distinguished French chemist and professor, died in Paris on the 6th of April, at the age of 103 years.

PROFESSOR NOTHNAGEL has been granted the title of Hofrath (Court Counsellor).

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÂ."

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*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.*

## Original Articles.

### PRESIDENTIAL ADDRESS.\*

BY L. S. M'MURTRY, A. M., M. D.

*Fellow-members of the Kentucky State Medical Society,  
Ladies and Gentlemen:*

Thirty-eight years have elapsed since a convention of physicians was held in the Senate chamber at Frankfort to consider the necessity of organizing a State medical society. In effecting permanent organization the constitution, which was a model of simplicity and conciseness, declared the purpose of the organization in this language: "First, the cultivation and advancement of medical science and literature by the collection, diffusion, interchange, preservation, and general circulation of medical knowledge throughout the State. Second, the establishment and maintenance of union, harmony, and good government among its members, thereby promoting the character and usefulness of the profession."

In October, 1852, the second annual meeting was held in the Circuit Court room in Louisville, when the real work of the Society was inaugurated. At this meeting the original members were nineteen (19) in number, and included the familiar and memorable names of Breckinridge, Chipley, Dudley, Flint, Force, Gross, Miller, Letcher, Richardson, Sutton, Sneed, and Spillman. Forty-six (46) physicians were added to the membership at this meeting. Among

others the names of Bell, Caldwell, Ewing, Hewitt, L. P. Yandell, Lewis Rogers, Powell, Bartlett, Wible, Peter, and Bullitt are found, names familiar to Kentucky people and to students of medical science.

At this meeting Professor Henry Miller made a report on the Progress of Obstetrics, a duty for which his original work and superior knowledge eminently fitted him; and Professor Gross read his famous report on Kentucky Surgery. Dr. W. S. Chipley contributed a report on Vital Statistics, in which he gave an exhaustive account of the sanitary condition of the State, illustrated by a valuable map, prepared under his direction, the result of a sanitary survey of the State. The counties are arranged in colors with reference to their mortality and the prevalence of disease. Dr. C. H. Spillman, of Harrodsburg, who is still among us, respected and honored, made an elaborate report on the Indigenous Botany of Kentucky. The first volume of Transactions was indeed a most valuable contribution to medical science and literature. The work done at this meeting demonstrated two important facts: first, that an organization for promoting the science of medicine and improving the sanitary condition of our people was needed; second, that the profession in Kentucky was thoroughly imbued with the scientific spirit, and in ability, culture, and attainments, conspicuously in advance of the age.

Briefly and imperfectly I have sketched the origin and foundation of the Society which has assembled here this evening in its thirty-fourth annual session. At the time to which I have referred, 1851, there were 982,405 inhabitants in the State of Kentucky and 1,470 physicians. In Lex-

\* Delivered before the Kentucky State Medical Society, Richmond, May 8, 1889.

ington, afterward removed to Louisville, a center of medical education had already been established, drawing to its instructions large numbers of pupils from the great domain west and south of the Alleghanies. The fame of McDowell, Dudley, Drake, Caldwell, Gross, and their colleagues had already extended far and near. These were the surroundings in which our predecessors labored. And now that thirty-eight years have elapsed, with regular annual meetings, save during the four years of civil war, may we not pertinently inquire, What has been accomplished? How can we of the present best discharge the duty committed to us by our predecessors? What of the future? These are questions which well deserve our thoughtful consideration.

As has already been stated, the original constitution declares the chief and first purpose of this organization to be "the cultivation and advancement of medical science and literature by the collection, diffusion, interchange, preservation, and general circulation of medical knowledge throughout the State." The earnestness of this purpose was attested in 1852 by the historic papers already mentioned, which may be found in the first volume of our Transactions. The time at my command will not permit even an enumeration of the many important contributions to medical science and literature made through the medium of this Society and published in the Transactions through all these years. Elaborate researches and clinical studies bearing upon the various departments of pathology, surgery, and midwifery constitute the major portion of Transactions. Through the several standing and special committees all the great advances in medical science and every improvement in the art of medicine and surgery have been quickly brought to the attention of the Society. Papers bearing upon improvements in medical education have found a place almost every year, and questions relating to sanitary science have been a conspicuous feature of our proceedings. By oft-repeated suggestions and

indefatigable labor, through appropriate committees, the act of the General Assembly establishing the State Board of Health was secured. More recently, by the exertion of the able and efficient executive officer of the Board of Health, with the active co-operation of this Society, our legislature was brought to realize the importance of further protecting the public health and to pass a law regulating the practice of medicine in this State.

The custom of holding the annual meetings at various points in the State, observed since the foundation of the Society, has of itself promoted the declared purpose of the organization by awakening the profession's interest in scientific work and diffusing knowledge. By this means, too, county medical societies have been developed and encouraged.

The second purpose enunciated in the constitution relates to elevating the character of the profession. Through the Society's proceedings, from the foundation to the present time, appeals have been made for elevating the standard of professional rectitude and exposing the evils of charlatany.

If time and patience permitted I might enumerate many of the indirect influences exerted by the Society in diffusing knowledge, improving the resources of our art, and advancing the public welfare. The charitable institutions of our State have at all times elicited the interest of the Society. Our delegates have annually occupied their places in the National Medical Association, and contributed liberally to its proceedings.

From what I have stated relative to the status of the profession in Kentucky at the time this body was organized, it is apparent that the standard of Kentucky medicine was conspicuously high. The metropolis of the State has continued to be, and is now, a center for medical education for the Southwest. The medical periodicals edited and published in Kentucky are numerous and of a high order of scientific merit. To these the members of this Society have been constant contributors. In 1879 it was

decided by the Society that its papers and proceedings could be best disseminated through the medical journals of the State, and the annual volume of Transactions was discontinued. The last volume published by the Society was the McDowell memorial volume, containing the oration of Professor Gross and other papers incident to the dedication of the McDowell Monument, which was erected by this Society in Danville in 1879.

An examination of the series of volumes entitled, *The Transactions of the Kentucky State Medical Society*, enables one to trace the progress of medicine through these years of intense activity in every department of our art. As knowledge grew apace, and concentration of energy with the necessary division of labor obtained, specialists in medical practice were developed. These gentlemen, representing the various specialties, have been for years past among the most active and valued contributors to the work of the annual sessions. At the same time the great body of the Society is composed of general practitioners, whose studies and observations in general medicine and energy compose the greater portion of our proceedings, and are equally instructive and valuable. Indeed here, as elsewhere in our profession, many of the most important and original contributions to medical science have emanated from the practical country doctor. So it obtains that the specialist brings here the results of expert training and concentrated labor to enrich the knowledge of the general practitioner, while the general practitioner strengthens and enlarges the specialist's knowledge in those lines wherein his work began, and with which his special work is of necessity closely related.

In thus glancing hastily back over the thirty-three annual meetings of the Society, it is not my purpose to present an optimistic view of our Society's labors and their results. Perfection is seldom attained in human institutions and human efforts. There are many features in our annual meetings which could be improved. Each

year witnesses improvement in some part of our exercises. This is probably most notable of late in the large number of papers presented at the meetings, in the discussions arranged beforehand by the secretary, and the improved arrangements for reporting and publishing the papers and discussions.

It would also be unfaithful to the record to depict our Society's history as a smooth career of harmonious discussions and unanimity of sentiment, opinion, and desire. Numerous breezes and a few storms have swept across our floor, but these are necessary to progress, and doubtless purify the atmosphere, encouraging wholesome growth.

Our organization has not been without its critics and reformers. The occasional attendant, who seldom if ever contributes a paper or participates in the discussions, expresses his disapproval of those most active in the Society's proceedings, claiming that they monopolize the time of the Society, forgetting that the attention of the Society can be readily had by himself whenever he chooses; unmindful, apparently, that the most active members are those who make the Society what it is, and extend its usefulness. The reformer appears upon the floor with resolutions to amend the rules and mode of organization of the Society, only to show oftentimes that he has not carefully read our constitution and by-laws. From time to time a momentary enthusiasm appears in the form of a proposition to organize a State society upon some ideal basis, forgetting that such institutions are built up through years of steadfast labor, and can not be created in full vigor in a night, overlooking the important fact that any suggestions looking to improved efficiency are sure of respectful attention upon this floor. The most certain and the speediest way to improve the efficiency of the Society is to attend the annual meetings and take part in the discussions.

If, in 1851, in our sparsely-settled State, our predecessors realized the necessity of an organization for the cultivation of medical science, surely the obligation to cherish

and promote the usefulness of that organization is now increased. The population of Kentucky has almost been doubled, the number of physicians greatly increased, and the science and practice of medicine and surgery advanced to a degree of perfection beyond the most sanguine expectations of the past generation. In all departments of our art is to be seen the greatest activity, and never before in the history of medicine was there such a demand upon the physician's powers to keep abreast in the line of advance. Our Society has been well to the front heretofore; let us see to it that the future is worthy of the past.

### PROGRESS IN PRACTICAL MEDICINE.\*

BY J. W. GILBERT, M. D.

Since Dr. Richard Bright's report of twenty-three cases of albuminuria associated with general dropsy, etc., in 1827, it has been customary among nosologists to call all those affections of the kidney comprehended in his report by his name, and consequently Bright's disease has become one of the most familiar names in medicine. Also, it has been the rule among pathologists to interpret the different morbid anatomical appearances found in different cases by attributing them to different stages in the process of the disease with the notion that the last stage is a result of the contraction of the products of inflammation. But, since the day of Bright, some have denied the correctness of this view of the disease. Dr. George Johnson, as early as July, 1859, claimed that the genuine contracted kidney had never passed through a previous stage of inflammation. (*Lancet*, July, 1859.) He believed that the apparent increase of the amount of interstitial connective tissue was only in a relative sense in consequence of the destruction of the glomeruli and epithelium of the convoluted tubes. Neither the clinical history of kidney contraction nor its symptomatology justifies the idea of pre-

viously existing inflammation. It is very exceptional, in fact, to find in a case of kidney cirrhosis a history of previous inflammation.

It is not shown to follow scarlatinal albuminuria sufficiently often to indicate a causal relation between the diseases. There has scarcely ever been found any general dropsy associated with abundant albuminuria, with tube casts, etc.; but, on the contrary, the contracted kidney has usually come on so insidiously that the patient and his friends alike have been unaware of any serious trouble until, as frequently happens, the case is ushered in by an apoplectic and epileptic seizure, or more likely, perhaps, uremic coma. He may have even believed himself in perfect health until a few minutes before he is *in articulo mortis*. If the patient is intelligent and apprehensive, he may have noticed some increased nocturnal micturition, the secretion being of a paler color, containing *less solids*. This symptom is only complained of because it disturbs sleep. While such sudden manifestation of the disease is by no means always the case, it is not at all uncommon, and even in those cases in which the patient is painfully aware of the gravity of his condition, which progresses with quite noticeable symptoms, gradual loss of strength, heart palpitations, etc., he does not show any general dropsy, as a rule no fever, in fact no symptoms of renal inflammation. In a typical case of parenchymatous nephritis, whether acute or chronic, the *ensemble* of symptoms is very characteristic. *The amount of urine per diem is always diminished, and the organic constituents are always increased.* "As long as the chronic inflammation of the kidneys continues to advance or remain at its height, the quantity of urine excreted daily is far below the normal." (*Ziem. Cyc.*, vol. xvi, p. 353.)

The albumen is never absent in the inflammatory disease; as a rule, other things being equal, the amount is in direct ratio to the activity of the inflammation. The same is true of urea and other normal constituents of the urine. In the contracted

\*Read at the May meeting of the Kentucky State Medical Society, Richmond, Ky., 1889.

kidney the reverse of this is true, the watery portion is increased and solids diminished in quantity. The cause of this renal degeneration is veiled in some obscurity; and, on account of its great similarity to cirrhosis of the liver, it has been assumed to be produced by the use of alcohol, without sufficient reason, however.

Bartel says, "Independently of avocation I am acquainted with no particular circumstances or habits of life which can be confidently designated as being the cause of this disease; above all I must enter my protest against the view which is wide-spread in England, although Dickinson certainly disputes its correctness, that the abuse of spirituous liquors favors the development of the genuine contracting kidney. In the first place, among all the patients whom I have treated, three only were brandy-drinkers to any notorious excess, while the greater number by far who were affected with this complaint had lived remarkably abstemious lives. In the second place, throughout my twenty-five years of active service as a hospital physician, I have had the most abundant opportunity of watching the consequences of intemperance both at the bedside and upon the *post-mortem* table; yet these three cases have hitherto been the only ones in which I have found atrophied kidneys in the bodies of habitual drunkards." (Ziem. Cyc., vol. xv, p. 412.) The causation is attributed now, by a great number of recent writers, to some faulty metabolism of nitrogenous substances in the liver; and that idea does not oppose the opinion of Bartel. For this faulty metabolism is not a condition that belongs to any special class of persons or to any particular vocations; as Fothergill, in his peculiarly attractive and quaint way has said, "Excess of uric acid does not necessarily depend upon very high living. This idea must be dispelled. At the same time it can be and very often is so originated. At other times it takes its origin in imperfect oxidation of the nitrogenized matter, which results from the splitting up of peptones in the liver into glycogen and waste azotized

matter. Very commonly it is the consequence of impaired functional activity in the kidneys. . . . Consequently lithiasis may show itself in a working woman as well as in a wealthy squire." (Fothergill's Hand-book, p. 276.) What particular substance is the specific agent in this morbid action is not stated, and the manner of its action is explained on various hypotheses. We will assume that it is a substance, the result of faulty metabolism or imperfect assimilation of nitrogenous food; whether it is uric acid, leucin, tyrosin, or whether all of these substances combined, is immaterial for our purpose at present. Many authors have found it associated with such conditions. Some have explained it to be a general affection of the arterioles and capillaries due to a constant irritant effect kept up by some morbid agent circulating in the blood. Notably among those holding this view are Gull and Sutton; others, and among them Mahomed, hold that the systemic agent acts through the nervous system, and, either by its local effect on the ganglia in the kidney or on or through the central nervous system, keeps up a constant spasm of the arterioles. This spasm increases the cardiac resistance and causes the cardiac hypertrophy, which in turn increases the spasm; but if we are allowed to assume from such experiments as Claude Bernard's on the parotid gland, which showed that stimulation of the sympathetic diminished the blood supply to the glands as well also as the watery secretion and size of it, but increase the organic constituents to a maximal limit, it would appear that the contrary would happen to that which actually does occur in renal contraction, if Mahomed's view is correct. Just the opposite obtains in the disease under consideration, the watery elements are increased, the organic diminished. This accords with the Bernardian experiment when he applied the induction current to the secretory nerve of the parotid gland. The blood supply was increased to the gland, as shown by incision of its substance; it would bleed more freely, the secretion was lighter and contained less

organic matter. By experiments on other glands of the body besides the parotid it has been tolerably well established that the glandular activity is controlled, other things being equal, by the nervous supply to the gland, and that a stimulation of the nerve supplying the gland from the spinal system increases the watery and saline elements of the secretion, and a stimulation of the nerve supplying it from the sympathetic system increases the solids characteristic of that peculiar secretion. In other words, one is a vaso-dilator the other a vaso-constrictor, one a secretory the other a trophic nerve. "The precise influence which special nerves exert upon the secretion of urine has not yet been positively ascertained. Some important facts, however, bearing upon this subject have been developed of late years. In his interesting and novel experiments upon artificial diabetes in animals, Bernard found that when irritation was applied to the floor of the fourth ventricle in the median line, exactly in the middle of the space comprised between the origin of the pneumogastrics and the auditory nerves, the urine was increased in quantity and became strongly saccharine. When the irritation was applied a little above this point, the urine was simply increased in quantity, but it contained no sugar." (Flint's Text-book of Human Physiology, p. 405.)

If we are justified in applying the results of such experiments to the kidney, and it is quite reasonable to assume that we are, it would seem more rational to explain the facts actually observed in kidney contraction by assuming that the morbid agent acted through the central nervous system and on the secretory instead of the trophic nerve. In the first place, the watery elements could not be increased at the expense of the solids unless the secretory nerve or vaso-dilator was affected, thereby giving the gland a greater blood supply, greater pressure or greater rapidity of the current. But this greater blood pressure could not be explained upon the idea of cardiac hypertrophy. It would not account for the urinary secretions being greater at night,

which is a well-known fact. Bartel says: "The fact is remarkable that the patients are invariably more tormented with the desire to pass water *by night than by day*. It appears that this greater frequency of the desire to micturate at night is founded upon the more abundant secretion that takes place at this time." (Ziem. Cyc., vol. xv, p. 432.) Nor has cardiac hypertrophy been shown always to precede the abundant nocturnal secretion. The *materies morbi*, during sleep and as a consequence of bodily quietude and of the inactivity of the skin, the bronchial and intestinal mucous membranes, and such organs as act vicariously to the kidneys, accumulate in the blood, thus stimulating more, the longer the body remains quiet, the central nervous organs and keeping up a greater blood supply to the glands. If this poison acted on the trophic ganglia, either in the kidney or centrally, and thus kept up a spasm of the arterioles, as maintained by Mahomed and others, the result would be an increase in solids in the urinary secretion until some maximal limit was reached and the gland became exhausted; also the specific gravity of the urine would be much greater, and would increase as bodily quiet was prolonged. The exact converse of this actually occurs. If the excessive secretion is due to cardiac hypertrophy, without taking into consideration the secretory nerve action—if, in other words, the excessive secretion is to be explained on mere physical laws, without any vital action of the gland itself, then it would have to be explained by the laws of osmosis, diffusion, and transudation. Tigerstedt and Santesson found that "while filtration takes place readily through dead animal membranes, nevertheless, when living membranes were used, such, for instance, as the lung of a frog, and filtration was attempted under the same pressure with serum or normal salt solution, no filtration at all was obtained. If the living lung tissue, that allowed no liquid to filter through it, was killed by heat, or by any other means, filtration quickly commenced." (R. H. B.

of M. Sciences.) Similar results were reached with other structures. As we have seen that the abundant urinary secretion can not be satisfactorily accounted for upon mere physical laws, the laws of liquid diffusion, neither can the cardiac hypertrophy be satisfactorily accounted for by the resistance in the kidney. It is very palpably ridiculous to assume that the kidney is diseased in consequence of the hypertrophied left ventricle. Yet the attempt is made to explain the first and most prominent symptom of its morbid action, viz., the excessive urinary secretion as a result of the hypertrophy, and consequent excessive blood pressure. As we have said, cardiac hypertrophy has not always been shown to precede the morbid action in the kidney, neither has the kidney affection been shown to precede the cardiac hypertrophy. There is a constant pathological condition which obtains in kidney cirrhosis, viz., endocarditis, endarteritis, and a thickening of the arterioles, one or all of which conditions are found more or less perhaps in every case. "The valves are frequently the seat of chronic endocarditis; the arteries throughout the body are often thickened, and may be calcareous." (J.W. Roosevelt, N. Y., R. H. B.) And the same author further says, "It is most probable that the lesions in the kidneys, and those commonly associated with them, are all due to some common cause. This common cause is found probably in arterial tension. It remains to be shown that high tension exists in all cases, and that it precedes the lesions. When this is done the cause of the high tension must be sought for, and it may perhaps be found in some substance, the result of faulty metabolism circulating in the blood and producing the vascular spasm, either by direct irritation of the vessels, or by its effects on the vaso-motor nerves.

The substances referred to in the above quotation, resulting from azotized food, may most probably be leucin, tyrosin, or uric acid, which substances are now known to be products of faulty metabolism. (G. V. Poore, London Lancet, Dec. 1888.) Nor-

mal products of tissue waste may also be active in the production of this kidney disease, when such substances are in an abnormal quantity, but that is as yet *sub judice*. It is most likely, however, the result of some abnormal constituent of the urine, and instead of this substance stimulating the trophic nerves and causing spasm of the arterial system, it is more likely that the initial condition is vaso-dilatation; for vascular tension would cause less blood supply to the kidney and greater specific gravity of the resulting secretion, for it would contain more solids and less water, and vaso-dilatation would cause a greater blood supply and an increased amount of water, which is just the condition that obtains in this affection. This vaso-dilatation would naturally result in a tissue hyperplasia, a hyper-nutrition of the whole arterial system through the vasa-vasorum. It is a well-known pathological law, that a structure is susceptible to inflammation in direct ratio to its functional activity, and that all structures have a maximum limit at which nutrition must stop and at which time—approaching functional exhaustion—they are the most liable to disease. Under these universal laws we find a ready explanation of the conditions in the several stages of the contracted kidney. We have already seen that endocarditis, endarteritis, etc., are found in renal degeneration; but I apprehend that they are never found as the initiatory condition. It would be improbable from the nature of the case, but hyper-nutrition and hyperplasia, and then inflammation, would be likely to be found in the order mentioned. It would be quite reasonable to expect that inflammation would result from the constant contact of the irritating *materies morbi* with such susceptible structures as the endocardium and vessels are found to be under these circumstances. Through the influence of this vaso-dilatation the coronary artery would naturally give a greater blood supply to the heart, and its muscle would develop to its maximal limit, as well as the circular muscles of the arteries—and so we find it. Con-

sonant with this idea of vaso-dilatation as regards the kidney itself, besides the excessive nocturnal micturition of a watery nature to which we have already adverted, the first morbid condition noticeable is a thickening of Bowman's capsule and a compression, from its contraction, of the glomeruli. "One very remarkable microscopical appearance is the great number of wasted glomeruli, which appear like dark round bodies, and in which the outline of the capillary coils is still plainly perceptible; they are often grouped together closely, and appear much smaller than the normal Malpighian tufts which still remain; they lie in the midst of the striped and fibrilated connective tissue, perfectly independent of the tubuli uriniferi. Round about these remnants of capillary tufts are recognized tissue bands which run concentrically round the glomeruli and unite in forming a close-fitting capsule around them." (Ziem. Cyc., p. 452.) Now, if we sum up some of the well-known pathological conditions which exist in this affection, we can find a "vicious circle" which culminates in the death of the affected part. We have the thickened and powerful heart, the arteries, with their muscular structures developed from an abundant nutrition, and, as a consequence, in the arteries the walls are non-resisting to the force of the blood pressure, which in turn compels the heart to greater effort. In the kidney itself a resistance is developed *pari passu* with the morbid states in the arteries and heart; so that the one aids the development of the other.

It is now a well-known clinical fact that the pulse is less compressible in this disease than normal—much less sphygmographic diastolicism is shown in the tracings. This condition is not peculiar to the radial artery, but obtains in the whole arterial system. It is manifest, therefore, that the recoil of the arterial system, which is a powerful aid in propelling the blood current, is lessened; if to a great degree, so that the second pulse-wave is not perceived in a sphygmographic tracing, it increases the work of the heart enormously. This condition is of itself

quite enough to account for the left ventricle hypertrophy, and, more than that, the two conditions are developed simultaneously, at least as far as is known. The usually accepted cause of the cardiac hypertrophy, the kidney contraction, is not enough. The renal artery is not large. If it were entirely obliterated, either gradually or suddenly, as by ligature, it would not nor could not of itself produce hypertrophy of the left ventricle. Other arterial areas, quite as large as the kidney, are obliterated without, so far as is known, instituting any hypertrophic enlargement of the heart. The question may be asked, Why no hypertrophy of the right ventricle, if the resistance in the kidney is not the cause? The answer which I offer is this: The right side of the heart is the venous side, and has always circulating in it venous blood. The veins are not affected in this disease; there is found no phlebitis, and the endocarditis is not found on the right side. The pulmonary artery is found thickened, but there is no endarteritis in it. Why? The answer to this question, so far as I know, has not been made. But my belief is that the active agent in the production of this disease is derived from faulty metabolism of nitrogenous products in the liver; and that so long as these remain in unoxygenated blood they are innocuous (existing, perhaps, in combination with carbonic acid in the form of a carbonate); but as soon as the carbonic acid is liberated by respiration they become active and are carried through the general blood current, and, coming in contact with the nerve centers, they produce vaso-dilatation; also, by their local action as an irritant on the heart and arteries, they cause in them a local inflammation and thickening of their walls; and finally, by their action on the kidneys, affect them in a similar way, being discharged from the body probably in the form of tyrosin, leucin, or uric acid.

The conclusion is, therefore, (1) That the contractive degeneration of the kidney is not an inflammatory disease, nor the result of inflammation. (2) That the morbid

agent in its production is a result of faulty metabolism of azotized food. (3) That the substance resulting from faulty metabolism is not necessarily dependent on any particular habits or vocation. (4) That it is most likely one or all of the substances known as leucin, tyrosin, or uric acid, etc., resulting from faulty metabolism. (5) That its activity is first manifested on the central nervous system, producing vaso-dilatation, and ultimately and locally on the heart, arteries, capillaries, and kidney. (6) That it is only noxious in arterial blood. (7) That its innocuousness in venous blood is probably due to its combination with carbonic acid. (8) That the kidney itself is affected first only by its increased functional activity, and the gland is finally degenerated by exhaustion, aided by the local irritative action of the *materies morbi*.

LAWRENCEBURG, KY.

### REPORT ON SURGERY.\*

BY W. L. RODMAN, A. M., M. D.

*Demonstrator of Surgery, Medical Department University of Louisville.*

The past year has been a very active one in surgical work. In truth, there has been so much creditable surgery done in different fields that your reporter finds himself surrounded, as it were, by an "embarrassment of riches." In selecting matter to bring before you, I have not been unmindful of the fact that in our body we have general practitioners and specialists. My aim has been to present points interesting to all.

#### SENN'S HYDROGEN GAS.

Of new things brought to light within the past year, Senn's hydrogen-gas test as a diagnostic agent in penetrating wounds of the gastro-intestinal tract is conspicuously the most brilliant, as it is perhaps the most useful. It demonstrates beyond a doubt the existence of a perforation of some part of the gastro-intestinal tract.

All who have ever performed laparotomy for a supposed perforation of the intestines have

felt the need of a certain means of diagnosis before opening the cavity. Symptoms are by no means uniform. In the four cases that I have seen operated upon it was a great relief to the operator to find the diagnosis of perforation confirmed when the abdomen was opened. I am sure such was the case the first time I operated, this being, so far as I know, the first operation of the kind in the State.

Hydrogen gas settles the question as definitely as an exploratory laparotomy. There is no danger in the former; considerable in the latter. Notwithstanding its certainty and harmlessness as a diagnostic agent, there are some who yet fail to use it. To fail to use it in medico-legal cases is to put one's self at a serious disadvantage.

For instance, a man is shot or stabbed in the abdomen. The surgeon supposes the intestines to be penetrated, but fails to confirm the diagnosis by insufflation of gas, and does an exploratory laparotomy. No wound of the intestines is found. The patient dies. At the trial of his assailant the shrewd advocate for the defense makes the plea that the man died, not from the wound, but as a result of the surgeon's knife. How can it be disproved? There is danger in any abdominal section. Hydrogen gas can be quickly generated for use in any case. Take a large bottle, put into it a few clippings of zinc, have the stopper perforated in two places, so as to pass through each a glass tube. Through one sulphuric acid and water are poured; through the other gas escapes and is conducted to a rubber balloon holding several gallons. The nozzle of an ordinary syringe furnished with a stop-cock is connected with the other end of the rubber bag. It is inserted into the rectum and the gas allowed to flow. An assistant makes pressure upon the anus to prevent the escape of gas. When gas passes the ileo-cecal valve a gurgling noise is heard. Gas finds its way into the peritoneal cavity if the gut be perforated, then escaping at the wound in the abdominal wall. Applying a light, it burns with a bluish flame. The diagnosis is now assured.

Relaxation favors the insufflation of gas. Its introduction also causes some pain; hence anesthesia must be induced.

\*Read at the May meeting of the Kentucky State Medical Society, Richmond, 1889.

I subjoin the twelve propositions of Senn :

1. The entire alimentary canal is permeable to rectal insufflation of air or gas.

2. Inflation of the entire alimentary canal from above downward through a stomach-tube seldom succeeds, and should, therefore, only be resorted to in demonstrating the presence of a perforation or wound of the stomach, and for locating other lesions in the organ or its immediate vicinity.

3. The ileo-cecal valve is rendered incompetent and permeable by rectal insufflation of air or gas under a pressure varying from one fourth of a pound to two pounds.

4. Air or gas can be forced through the whole alimentary canal from anus to mouth under a pressure varying from one third of a pound to two pounds and a half.

5. Rectal insufflation of air or gas, to be both safe and effective, must be done very slowly and without interruptions.

6. The safest and most effective rectal insufflator is a rubber balloon large enough to hold sixteen liters of air or gas.

7. Hydrogen gas should be preferred to atmospheric air or other gases for purposes of inflation in all cases where this procedure is indicated.

8. The resisting power of the intestinal wall is nearly the same throughout the entire length of the canal, and in a normal condition yields to diastaltic force of from eight to twelve pounds of pressure. When rupture takes place, it either occurs as a longitudinal laceration of the peritoneum on the convex surface of the bowel or as multiple ruptures from within outward at the mesenteric attachment. The former result follows rapid and the latter slow inflation.

9. Hydrogen gas is devoid of toxic properties, non-irritating when brought in contact with living tissues, and is rapidly absorbed from connective tissue spaces and all of the large serous cavities.

10. The escape of air or gas through the ileo-cecal valve from below upward is always attended by a blowing or gurgling sound, heard most distinctly over the ileo-cecal region, and by a sudden diminution of pressure.

11. The incompetency of the ileo-cecal valve

is caused by a lateral and longitudinal distension of the cecum, which mechanically separates the margins of the valve.

12. In gunshot or punctured wounds of the gastro-intestinal canal, insufflation of hydrogen gas enables the surgeon to demonstrate positively the existence of the visceral injury without incurring the risks and medico-legal responsibilities incident to an exploratory laparotomy.

#### PENETRATING WOUNDS OF THE ABDOMEN.

Senn's discovery has greatly increased the interest felt in this subject, and led to a more general discussion of it among surgeons everywhere. The result of it all has been to put laparotomy for penetrating wounds of the abdomen upon a sure footing. The surgeon no longer asks himself the question, "Am I warranted in performing laparotomy?" but he is more likely to say, "Can I conscientiously withhold the operation?"

Laparotomy is indicated (1) for hemorrhage into the peritoneal cavity; (2) for wounds of the hollow viscera. Recent statistics prepared by Dr. Coley, in the *Boston Medical Journal*, make a most favorable showing for shot wounds of the abdomen, which are confessedly more dangerous by far than stab wounds. He reports seventy-four cases, which he divides into three classes: (1) Those operated upon within twelve hours; (2) those operated upon after twelve hours; (3) in this class the time could not be ascertained. Class one, 39 cases, 18 recoveries, and 22 deaths—percentage of recoveries, 43.6; class two, 22 cases, 5 recoveries, 17 deaths—percentage of recoveries, 22.7; class three, 13 cases, 7 recovered, 5 died, 1 doubtful—percentage of recoveries, 57. Of 74 cases, 29 recovered—percentage of recoveries, 39.5.

These figures clearly indicate the advisability of an early operation. They also make a better showing for laparotomy than did the statistics made by Sir William McCormac in his most excellent monograph upon the subject eighteen months ago. He reported thirty-two operations, which embraced all published cases at that time, with a mortality of 76.5 per cent. The mortality has been reduced from 76.5 to 60.5 per cent.

Turning from these figures to the statement

of Otis, who says, in his *Surgical History of the War of the Rebellion*, "It may be doubted if a single incontestible case of recovery from shot wounds of the *small intestine* was observed," we find much to cheer us. Then, of course, the expectant plan of treatment alone was pursued.

The great Abernethy said of wounds of the intestines, "Nature would do nothing for such cases, but left them to their fate."

So, then, if practically all such cases die unoperated upon—for the few recoveries reported are but as exceptions proving the rule—shall we withhold an operation which saves more than one in three?

#### SURGERY OF THE BLADDER.

No viscus in the body has claimed more attention from surgeons everywhere during the past year than the urinary bladder.

Supra-pubic lithotomy has gained much in favor. Some of its more enthusiastic supporters have claimed for it an advantage over the perineal method in all cases. This, however, is an ultra position, and can not be sustained. Each clearly has its field. There are cases where it is unquestionably the better operation. In old subjects, in cases of large stone, and in encysted stone, supra-pubic cystotomy is to be preferred. In young subjects, small or average size stone not encysted, the perineal operation has the advantage. The high operation is the easiest done, but convalescence is shortened by perineal section. As to which is safer we can not yet say. Assendelft, who prefers the high operation, reports an unparalleled record. He operated one hundred and two times with only two deaths. Others operating by the same method have not approached such results.

His statistics in lithotomy are as Tait's in ovariectomy, unrivaled. In my judgment the judicious surgeon will not allow himself to become overzealous in the support of either operation, but will study his cases carefully and give each the benefit of the one which promises to meet the indications best. In supra-pubic cystotomy the bladder walls can be sutured or not. In general it may be

said that, when operating for stone, the walls should not be sutured, as there will be cystitis requiring free drainage. The incision can be made in the median line, or transversely, just above the symphysis pubis. The latter incision is said to be best in obese subjects; it gives more room, the bladder being more easily reached, and its interior more satisfactorily inspected. Trendelenburg, who has had most experience with the transverse incision, greatly prefers it. (It is incorrectly called his operation, though it was first suggested by Günther thirty-seven years ago.) It is thought that hernia is more likely to follow the cross than the vertical incision.

#### TUMORS AND FOREIGN BODIES IN THE BLADDER.

However surgeons may differ as to the merits of epicystotomy and perineal section for stone, there can be but one opinion as to which is best for tumors and foreign bodies. Epicystotomy has every advantage. Here the ideal after-treatment is to suture the bladder walls, as they are not diseased, and the bladder requires no drainage. The improved cystoscopes of Nitze and Leiter have made the diagnosis of tumors and other substances within the bladder comparatively easy, and opened a new field of diagnostics.

#### CYSTITIS IN WOMEN.

Dr. Madden, of Dublin, believes that cystitis is both more frequent and serious in the female than in the male. He claims that the best way to treat cystitis is to dilate the urethra and neck of the bladder with the finger, then curette the proliferating mucous membrane and apply carbolic acid over its entire surface. He uses the glycerole of carbolic acid of the British Pharmacopeia. This treatment is to be used two or three times, at intervals of a week. It effects a cure in the most aggravated cases. He objects to Emmet's button-hole operation, upon the grounds that it is difficult to keep the fistulous tract patulous long enough to drain the bladder sufficiently, and that it is sometimes very difficult to close the fistula when it is desirable to do so.

## ILIAC ABSCESS.

Abscesses arising from diseases of the cecum and vermiform appendix have been much discussed during the past year. In a most interesting discussion by the Surgical Society of New York, the late Dr. Sands took the ground that they were subperitoneal, and should not be operated upon before the tenth day, so that adhesion of the peritoneum will have taken place. Weir and others held that they were usually intra-peritoneal, and for this reason should be operated upon not later than the third day.

Early operation promises the most.

## DERMOID CYSTS OF THE NECK.

Dr. Keetley, of London, recently operated upon a large dermoid cyst of the neck, extending from the lower jaw to the clavicle. He intended excising the tumor, but, finding its attachments so deep and extensive, abandoned the idea of excision, and, instead, cut away a portion of the cyst wall, sutured it to the skin, and stuffed it with gauze after cleansing thoroughly. This is certainly quicker and safer than excision, and Keetley suggests it as a plan of treatment in all similar tumors. The result in his case was highly satisfactory.

## WHITEHEAD'S OPERATION FOR INTERNAL HEMORRHOIDS.

While it has here and there gained the favor of some of the best men doing rectal surgery, it is not likely to ever gain the extended use given the ligature. Consisting, as it does, of a complete excision of the pile, it is necessarily more difficult, protracted, and bloody than other operations. Whitehead claims that there is much less pain after his operation than the ligature; that convalescence is materially shortened, and there is little or no tendency to retention of urine, which so commonly follows the ligature.

Piles with prolapsus can perhaps be operated upon by Whitehead's method to the best advantage.

## ALEXANDER'S OPERATION.

This operation, which was done so often several years ago, has, comparatively speaking,

fallen into disuse. Your reporter fails to see how shortening the round ligaments can materially change the position of the uterus. They are too delicate to support much weight. Anatomically considered, they can at most only draw the uterus forward; therefore the operation is intended only for retroversion without fixation.

## LACERATED PERINEUM.

Dr. Dudley, of New York, has recently described a new operation for lacerated perineum. It differs from the operation of Emmet in the method of taking the stitches.

In our judgment neither of these operations is comparable to that of Mr. Tait. It is difficult to understand how any one who has ever performed Tait's operation could seriously think of doing any other. It is quick, showy, and brilliant.

## TREATMENT OF CARBUNCLES.

Edmund Owen, of London, advocates the treatment of carbuncles by erasion. He has operated upon the largest carbuncles, and is highly pleased with the result. He cuts away all slough and undermined skin, scrapes thoroughly with a Volkmann's spoon, and dresses it antiseptically. In this way a painful and septic mass is converted into a painless and aseptic one.

Excision of carbuncles is advocated by Gerster and others. Your reporter has twice done this with such gratifying results that he is induced to believe that it constitutes one of the best means of treatment.

## FRACTURES OF THE LOWER EXTREMITY.

Colles, of Dublin, holds "that a change from the horizontal to the sitting posture is injurious to patients with fractures of any of the bones of the lower extremities, by showing that as the patient rises into a sitting posture the extremity of the ischium is used as a fulcrum, and, as the head of the femur is at least three inches above that point when the patient is horizontal, it must be pushed downward two or three inches. This must influence the point of weakest resistance, the seat of fracture."

## HERNIA.

Perro advocates the following method for reducing strangulated hernias. The pelvis is raised upon a pillow, thighs flexed and *abducted*; "the scrotum and hernia are seized by the left hand and elevated toward the abdominal walls, and pressure made upon them. The index finger of the right hand is passed into the inguinal canal, and by a boring and rotating pressure is directed toward the horizontal portion of the pubis." In a short time the hernia disappears. He has succeeded in six instances where taxis as ordinarily employed had failed.

## A NEW TREATMENT FOR ANEURISMS.

Macewen, of Glasgow, advises as a treatment of aneurisms the introduction of needles into the sac until the endothelial lining of the opposite wall is reached. The oscillation of the needles scratches the endothelium and causes proliferation of the leucocytes, which are said to form a firm, fibrous mass. A demonstration of the operation was made by Macewen March 9th. It is not difficult to understand how the introduction of needles favors coagulation, and in this way cures an aneurism; but it is far from easy to believe that scratching the endothelial lining of a vessel leads to proliferation of leucocytes, which form a firm fibrous mass. Your reporter thinks the treatment based upon unsound pathology. In the first place there will be no epithelial coat to scratch with the needles in surgical aneurisms, as it will have ruptured before the surgeon sees it. But little dilatation of a vessel is necessary to rupture the inner coat. Secondly, there will be more or less laminated fibrin in the vast majority of aneurisms. As this tissue never becomes organized, it is unlikely that leucocytes in its midst so soon proliferate. I can not leave the subject of aneurisms without remarking that this and other operations, with intrinsically no more to recommend them, would not be practiced if the merits of compression as a treatment were generally appreciated. There will be few aneurisms which will not yield to compression in some form.

Compression may be digital, instrumental, and by Esmarch's bandage, in the order named.

While digital compression is almost absolutely safe, it is followed by cure in 75.3 per cent of cases.

Digital compression is to be made by a relay of assistants, and is to be applied to the main artery either upon the cardiac or distal side of the sac. The former is much to be preferred.

Instrumental compression is made by some one of the many tourniquets, weights, etc. Results from this plan of treatment are quite if not more satisfactory than from digital compression. The mortality may be somewhat greater, but the percentage of cures is also greater.

Broca rigidly analyzed 127 cases treated by instrumental compression; 116 recovered—per cent, 91. There was no mortality in 127 cases.

A means of treatment, which in my judgment will prove more satisfactory to the busy surgeon than either of the former, is compression made with Esmarch's bandage—first practiced in 1875 by Reid, of the English navy. It is applied as follows: The bandage is applied firmly from the distal extremity of the limb up to the sac, then lightly over the sac, then firmly again until a point well above the sac is reached. As considerable pain results after the first thirty minutes, it is best that the patient be lightly chloroformed. The bandage is kept on from thirty minutes to two or three hours. One application usually suffices to effect a cure. The advantage of this treatment is the short time required when compared with digital and instrumental compression. It cures 85 per cent of all cases.

The treatment of aneurisms by the ligature does not deserve the popularity it enjoys. Norris and Stephen Smith show it to be followed by a mortality of 33 per cent. It should never be practiced unless compression has failed to effect a cure.

## PULMONARY SURGERY.

The lungs, for so long considered sacred territory, have capitulated and fallen within the domain of the surgeon's knife. There have been reported to date eighteen cases of pneumotomy done for pulmonary abscess. Nine, or fifty per cent, were successful. The prognosis is better when the abscess connects with the pleural cavity.

Russian surgeons have been particularly active in doing pneumonotomy. Opensovsky, who records a remarkable case of pneumonotomy for an abscess following pleuro-pneumonia, gives the following rules:

1. Pneumonotomy sometimes represents the only means of saving life in pulmonary abscess.
2. The operation is borne quite well.
3. It should be undertaken as early as possible; that is, as soon as a pulmonary abscess has been diagnosed.
4. It is advisable to excise fairly long pieces of ribs and to make a free incision into the cavity, in order to secure a thorough removal of its contents and a thorough disinfection of the parts.
5. A thorough disinfection of pulmonary cavities seems to be endured without any untoward accidents.
6. Firm pleural adhesions constitute an important requisite for a successful issue of the operation, since they prevent suppurative pleurisy and make easier both the discovery of cavities and the removal of their contents.

#### PNEUMONECTOMY.

Dr. Zakharevitch, after a series of well conducted experiments upon dogs and rabbits, advises pneumonectomy in man. Others have reached the same conclusion.

He operated upon thirteen rabbits, with two deaths, and seven dogs, with three deaths. From one lobe to an entire lung may be excised. A dog with only two lobes left him lived four years in perfect health, then dying of intercurrent disease. He says that "a minimal respiratory area compatible with life and health amounts to two pulmonary lobes."

These experiments lead to the hope that in time such operations can be done upon the human subject where only one lung or a part of it is diseased.

#### ANESTHETICS.

During the past year there has perhaps been no subject more generally discussed at the meetings of various medical associations and in the editorial pages of leading journals than the relative merits of the two leading anesthetics, ether and chloroform. Exhaustive papers upon the subject from all parts of the civilized world could be referred to. It is putting it mildly to

say that chloroform has not suffered by the comparison.

While your reporter is prejudiced in favor of chloroform, a spirit of candor compels him to admit that the primary dangers from its use are greater than those from ether. Offsetting to a considerable extent, at least, this advantage which ether seems to have, are its secondary dangers. Until recently, even now they represent an unknown quantity.

Deaths which have been recorded as due to pulmonary edema, bronchitis, pneumonia, uremia, nephritis, etc., following surgical operations, have unquestionably been due to ether.

Such can not be said of chloroform, as it kills quickly when it does kill. Notwithstanding the literature of the subject, there are to-day many surgeons who believe in the almost absolute safety of ether. This is easily disproved.

In a paper read before the New York Academy of Medicine Dr. Weir reported 5 deaths from ether in 10,789 surgical operations. Another surgeon reported 2 deaths in his own practice in as many months. These figures do not include deaths due to etherization occurring some time after operations.

It is interesting to note that Hunter McGuire reports 28,000 cases of chloroform anesthesia without a death, Nussbaum 40,000 without death, and a surgeon in India nearly 45,000 administrations with the same result; and yet some who use ether recklessly are as afraid of chloroform as the "devil of holy water."

Contrary to the general teaching upon the subject, ether may kill by heart failure as well as through the respiration. Of 40 incontestible cases of deaths from ether, 10 died at the heart first.

It is not to be expected that ether will ever supplant chloroform, or chloroform ether. Nor is it to be desired. It is fortunate that we have both agents to avail ourselves of. Each clearly has its field of usefulness. What is to be hoped is that surgeons will make careful examinations of patients before giving either anesthetic. I doubt not that the time will come when all patients will be as carefully examined before an anesthetic is chosen as they would be if applying for life insurance. By doing this the danger will be minimized.

Chloroform is to be rejected in all persons with degenerative changes in the heart. Valvular disease is no contra-indication if the organ functionates well.

In anemia and nervous prostration chloroform is more dangerous than ether.

Ether is contra-indicated in all pulmonary disease, in nephritis, and in all operations where the after nausea and retching are, for evident reasons, undesirable. On account of its great inflammability it is not to be used at night, nor in the day when the actual cautery is to be used. It is also contra-indicated in surgical emergencies where the stomach is full, on account of its greater liability to provoke vomiting.

Neither is well borne in advanced Bright's disease; chloroform is the safer. In childhood chloroform is always to be preferred. In advanced age it is yet an open question as to which is the safer agent. If there be fatty degenerations, chloroform is out of the question. In pulmonary troubles, which are so common with the old, ether is contra-indicated.

I am loath to leave the subject of chloroform without a word as to the method in which it should be administered.

Statistics, if they prove any thing, clearly show the death-rate from chloroform to be in a great measure due to faulty administration.

The common practice of urging patients to "take long breaths" and to "suck it in" at the commencement of anesthesia can not be too pointedly condemned. Chloroform is the most powerful of all anesthetics, possessing the inherent toxic property to the greatest degree, and for this reason should be given most cautiously, so that the system will become gradually accustomed to its use and the respiratory and cardiac centers in the medulla not overwhelmed at the outset. By a slow administration spasm of the glottis is also prevented.

The method I have seen Prof. Yandell follow so often is, I think, the best. He allows the patient to begin the administration, and when he is getting well under the influence of the vapor takes it from him. The timidity of the patient will be an effectual barrier to his becoming too rapidly anesthetized.

The danger is directly proportional to the

amount of the vapor in the blood at a given time.

Another very common error is for the operator to be continually suggesting to his anesthetist how to do his work. Frequently we hear from him such remarks as "Push it, doctor; don't be afraid of it," and the like.

A timid or nervous anesthetist, especially if he be less experienced than the operator, is apt, in his endeavor to please his chief, to be too lavish with his chloroform. We have all seen this too often.

To bring my report within time limits, interesting matter has necessarily been eliminated.

LOUISVILLE.

### REPORT ON PUBLIC HYGIENE.\*

BY J. N. M'CORMACK, M. D.

*Secretary State Board of Health.*

I have the honor to submit my report as the representative of this Society in the matter of the indorsement of diplomas under the new medical practice act. At a conference of representatives of all the six bodies authorized under the law to indorse diplomas, viz., the four medical colleges of the State, the State Medical Society, and the Homeopathic State Medical Society, held in Louisville during the month of September, the entire matter was placed in my hands as your legal agent. Shortly afterward a circular letter was published widely throughout the State, addressed to the medical profession, explaining the provisions of the law, and defining their duty under it. At the same time a personal letter was sent to each of the one hundred and eighteen county clerks defining their powers and duties, all this being done under the advice of excellent legal counsel. In order to facilitate registration, and the better to secure the moral support of the body of the profession, I announced at the outset that I would charge no fee for the indorsement in any case. I am pleased to be able to report that the law has been very generally complied with, and with less friction and complaint from physicians, so far as I am informed, than has been usual in other States.

\* Read at the May meeting of the Kentucky State Medical Society, Richmond, 1889.

In some counties improper registrations have been made, but, so far as I have been able to judge, this has usually been due to the fact that no medical man in such county took an interest in the matter and insisted that the clerk should adhere to a strict construction of the law. This does not apply to the county of Jefferson, where the real test of the law must be made, as has been the case in the enforcement of similar laws in the large cities in other States. Here shrewd, enterprising but unscrupulous charlatans have built up large practices, have often accumulated considerable wealth, and of course will not yield their prospects for further ill-gotten gains without a contest. This contest the medical profession is preparing to force, and the final result can hardly be a matter of doubt.

The number of men illegally engaged in practice was found to be large. Scores of such men have been forced out of the State, many others have been required to attend the various medical colleges, and many of the most disreputable charlatans from Indiana, Ohio, Tennessee, Iowa, Michigan, and other States have been kept out of the State.

Two or three amendments were made to the law in the course of its passage through the legislature, which to some extent mar its efficiency, notably the provision empowering medical societies to indorse diplomas; but it is hoped that there will be little trouble in having the next legislature cure these defects. Whether this is done or not, the law is a long step in advance, especially if its strict enforcement secures the support of the profession in each county.

On the first of January I will receive the reports from each county, after which I shall publish an Official State Medical Directory, giving the name, age, place of birth, address, and place and date of graduation of each physician in the State.

The labor involved in the indorsement of nearly one thousand foreign diplomas, involving as it did the unpacking, packing, and shipping of as many packages, has been very great, but I will have been fully compensated for all this work, if I can have that support from this Society and the physicians throughout the State necessary to secure the protection to our people and profession which this law makes possible.

## REPORT ON PROGRESS IN OBSTETRICS.\*

BY J. G. CECIL, B. S., M. D.

*Assistant to the Chair of Obstetrics and Gynecology, Medical Department of University of Louisville.*

No great stride in obstetric science marks the past year, but all along the line there has been steady advance. It is therefore not in my power to announce any great discovery of such paramount importance as to claim exclusive consideration. There are, however, many subjects about which much that is interesting and instructive could be written.

Without endeavoring to compass the whole field, it will be the aim of this report to call brief attention to a few subjects that appear to have engaged attention most prominently since this Society has heard a *resumé* in this department.

### ASEPTIC OBSTETRICS.

The art asepsis can claim a larger share of praise for wondrous improvement in the last quarter century than any or all together advances that have been made. This change, wrought by the application of the scientific principles of cleanliness, is not so apparent to those who only do private practice, but to hospital obstetricians the revelation is simply marvelous, and as grand as it is marvelous. To the physician in private practice who delivers hundreds of women, rarely seeing evidence of septic infection, this does not appeal with such terrific force as it does to men in charge of lying-in hospitals, who saw ten, fifteen, twenty, or even thirty per cent of their cases die from blood poisoning. The same hospitals that twenty-five years ago were obliged to record this frightful mortality, now, with pride equal to their quondam shame, point to records of mortality in many instances less than one per cent, a record scarcely equaled, and not surpassed by the most skillful practitioner of obstetrics in the healthiest rural community. One or two examples of what has been accomplished will be cited, these being the representatives of instances too numerous to

\* Read at the May meeting of the Kentucky State Medical Society, 1889.

mention, not all so remarkable as these, but to characterize as creditable in the highest degree is faint praise. "In the Marbourg Obstetric Clinic and Polyclinic, for the year ending March 31, 1888, 308 were confined, with no deaths; seventy per cent were entirely free from any *post-partum* rise of temperature." (*Deutsches Medisches Wochenschrift*, 1888.)

"From May 1, 1886, to May 1, 1887, 1,403 women were delivered at Leopold's clinic with not a single death from sepsis. In the last 500 confinements the septic morbidity was limited to one case of parametritis. The spirit of emulation has practically ceased as to the death-rate, but is now directed to the prevention of all troubles arising from septic infection. Two or three decades ago, to send a woman to be confined in a lying-in hospital was said to be equivalent to sending her to the gallows; now, the reverse of that picture is, that the safest place for a woman to be delivered is in a well-appointed hospital.

Whence this truly great advance that even the private practitioner must acknowledge and will do well to bear in mind? It is answered in one word, *cleanliness*. As is usually the case, the pendulum swinging too far, and the very elaborate rules of precaution, drawn up and valiantly contended for a few years since by Gaillard Thomas, are now generally regarded as too ponderous and impractical to be carried out; so the refinement of such preparation, as indicated by him, is now generally regarded as unnecessary and is quietly ignored, while the essential principles are retained.

The use of the bichloride of mercury in obstetric practice has greatly diminished. Only the weakest solutions are used, and by many it is relegated to the things of the past.

One more word on this part of the report and we pass: that is, those who practice surgery ought to observe double precaution when doing obstetric work. When civil authorities recognize the truths embodied in this great discovery, and time will reveal it even to them, surgeons will be prohibited from practicing obstetrics.

#### DELIVERY OF THE AFTER-COMING HEAD.

Two articles, one by Dr. Philip Schiedt, Philadelphia (*American Journal Obstetrics*, March, 1888), the other by D. H. C. Coe, New York (*Medical Record*, Jan. 19, 1889), call attention to this matter, often discussed, but ever interesting and important. Winkel, at a recent meeting of the German Society for Gynecologists, referred to twenty-one methods of extracting the after-coming head. He considered that procedure best which combined pressure externally with maintenance of the head in that position best suited for delivery, which is, the trunk and arms, when born, are raised, two fingers in the child's mouth at the base of the tongue by which flexion is secured. He makes pressure with the other hand through the uterus upon the head.

Recalling the infant mortality, which varies from nine per cent (Dubois) to thirty per cent (Churchill), any thing looking to the improvement of such statistics certainly merits continued attention. These two papers advocate with much force the application of forceps to the after-coming head, hastening delivery, even at the probable risk of cervical and perineal lacerations. The almost uniform success now obtained in the operations, both immediate and secondary, for the repair of these accidents impel us to certainly hesitate less in using forcible delivery when the life of the child is in such imminent peril.

"It often happens that we are consulted by an old primipara who has been led to believe that she can not have a living child, or by a multipara who has borne several dead ones. Such women are extremely anxious that the infant should be saved at all hazards, and will make light of severe lacerations if we are successful in obtaining their wish." (Dr. Coe, *Medical Record*.)

The following point is emphasized by Prof. Anderson, of Louisville: Often we see the birth of the child arrested and its life sacrificed after the head has reached the floor of the pelvis. Fruitless efforts are made to turn out the head, while the fact that rotation at the outlet has not occurred and is overlooked.

The womb is now acting at a very great disadvantage, a little aid from the obstetric hand will cause the necessary rotation. The turning-out process is thus easily and safely accomplished, which before was mechanically impossible. Any thing that causes delay of the head in its descent must be overcome. After the cord ceases to pulsate, a very few minutes' delay means life or death to the child.

The argument in the two papers is, that as time is the great factor, and as the forceps can be applied in two or three minutes, therefore the time that is so precious is saved by use of the forceps, especially since the most vigorous supporters of the manual method declare it requires from five to six minutes to extract the child's head.

#### MANAGEMENT OF THIRD STAGE OF LABOR.

There appears to be an ever vernal contest, especially among our German brethren, over the management of the last stage of labor, the active expression of the after-birth, as opposed to the expectant method. This brings into the arena the brightest minds in Germany. Credé, whose name is immortalized by association with the active treatment known as his method, leading one party; and opposed we have Ahlfeld, Dohrn, and others advocating the expectant plan. Freund, of Strassburg, has said recently, very truly, that "an understanding between the advocates of the two methods is rendered difficult by both sides assuming an arbitrary point of time when the placenta is to be removed." A point of difference also is the method of the separation of the placenta, this being the fundamental truth on which the respective plans are based: The partisans of the Credé method claiming that the separation takes place by reason of the uterine contractions tearing loose the placenta, first on the edges, and gradually extending toward the center until the separation is complete; the other side contending that the placenta is detached first at the center, and a retro-placental hematoma forms, and by its gradual increase the complete detachment is effected, this hematoma

forming during relaxation of the uterus. It is worth while in passing to note an ingenious and plausible theory recently advanced by D. Berry Hart (Edinburgh Med. Review, October, 1888), which is, "Placenta and membranes separate when there is a disproportion at the plane of separation between their area and their site of attachment." This disproportion between the placenta and its site brings about tension on the trabeculæ of the trabecular layer, and results in rupture of tissue. This occurs during relaxation following a pain in the third stage. The placental site is subject to increase during relaxation; the placenta, now bloodless or nearly so, does not respond, hence the disproportion.

There is little doubt but that either misconception or misapplication of the Credé method has resulted in unfavorable results, and as a consequence unjust criticism. The strongest objection urged against this plan is, that if expression of the after-birth is attempted too soon there is danger of tearing the membranes and retention of parts of them. The only serious *post-partum* hemorrhage that I have ever experienced was most probably induced in this way. The best that is claimed for these methods are, that the Credé, or active expression of the placenta, is that it is only in the direction of assistance to nature; and, for the expectant plan, that it is purely a physiological process, the uterus is entirely capable of performing this function and ought not to be interfered with. Ahlfeld very pointedly remarks that "the physician must be ever conscious that in performing Credé's method he is disturbing a physiological process, and the responsibility for the consequences due to this disturbance must unquestionably be assumed by the physician.

The mistake that is most often made is that of undue and unnecessary haste in delivering the after-birth, begotten of an exaggerated fear of an improbable accident. Extreme views are rarely correct in every part. The conclusions arrived at by your reporter, after carefully weighing the arguments adduced by both sides, is a compro-

mise. With Ahlfeld, wait, not necessarily an hour and a half, the length of time named by him, but until it can be reasonably ascertained that there is complete detachment of the placenta and membranes. Then, if the uterus be slow or unable to deliver, assist in the expression by the Credé plan. Leaving the separation to occur according to nature's method, whatever that may be, our information on this point is certainly not absolutely settled. It is a misapplication of the Credé method to attempt assistance of the detachment of the secundines; it is equally needless that we wait, as advised by Ahlfeld, for hours, if necessary, for the extrusion of the placenta through the vagina. There can be little harm in the introduction of a clean hand into the vagina for the purpose of removing a loose placenta.

#### CESARIAN SECTION V. CRANIOTOMY.

Cesarian section of the recently modified forms, as opposed to craniotomy, has engaged the attention of obstetricians throughout the world very much of late. The literature of the subject is very full, and the collation of statistics has been vigorously looked after. It is obvious that the limits of this report will forbid any extended discussion of this subject, yet your reporter would be remiss not to mention it. The trend of opinion among obstetric surgeons seems to favor the modified cesarian section to craniotomy in all cases where the child is living. The prediction is freely made that a few years will render the latter operation obsolete, notwithstanding the fact that the mortality from the improved methods of doing craniotomy has been reduced to a very small per cent, or to nothing in some hospitals. The necessary sacrifice of living children under this operation, considered in connection with the striking success attained in abdominal section, combine to strengthen the conviction that the most heroic of all obstetric operations will eventually supersede the operation of craniotomy.

Dr. Busy, of Washington, in a recent elaborate paper has taken the extreme view that craniotomy ought never to be done on

the living child. He has labored quite industriously to sustain his position by statistics; while not very successful in this part of his argument, from the humane and moral aspect of the question he has made out a very strong case.

The best that can be claimed for American cesarian sections, in the hands of skilled surgeons, is a mortality of forty-five per cent to mothers and about ten per cent to children. The results obtained by Germans and Austrians are superior to those of Americans. The most recent data as collected by Caruso (*Arch. für Gynecol.*) show that the mother has three chances out of four and the child nine out of ten. The recent remarks of Mr. Tait are characteristic of the man, and exhibit his confidence in the future of the procedure. He says, "The operation of amputation of the pregnant uterus, I venture to predict, will revolutionize the obstetric art, and in two years we shall hear no more of craniotomy or eviscerations, for this new method will save more lives than those proceedings do, and it is far easier of performance. It is the easiest operation in abdominal surgery, and every country practitioner ought to be able and always be prepared to do it."

#### TREATMENT OF EXTRA-UTERINE PREGNANCY.

The consensus of opinion concerning the treatment of extra uterine pregnancy is rapidly narrowing itself down to primary laparotomy to the exclusion of all other modes. Quite a number of American obstetricians adhere still to the use of electricity. Others agree that the electric current may be used with safety and certain beneficial results up to the third month of gestation. There can be no doubt that the fetus is easily destroyed by electricity, but those who have practiced this mode of treatment are not so unanimously agreed as to what becomes of the products of conception, or as to the efficacious nature of the current upon the tumor remaining. Mr. Tait, whose record in the management of these cases entitles him to an authoritative opinion, says, "The element of danger is not the fetus, if killed by

electricity, but the placenta; this may go on developing enormously after the fetus has died from natural causes. This has been proven by the observation of Berry Hart and confirmed by Knowsly Thornton." The tendency after electrolytic treatment is toward suppuration septicemia and its various contingencies (Currier); this, with the uncertainty as to future of the tumor that is left and the immediate danger of the treatment, together, more than counterbalances the dangers incident to primary laparotomy.

From all reports we agree with Mr. Tait that abdominal section is the procedure that promises the most certain and safest results in ectopic gestation before rupture occurs. After rupture there can be no difference of opinion.

LOUISVILLE.

## Societies.

### THE KENTUCKY STATE MEDICAL SOCIETY.

Proceedings of the Thirty-fourth Annual Meeting, held at Richmond, Ky., May 9th, 10th, and 11th,\* Dr. L. S. McMurtry, of Danville, President, in the chair.

FIRST DAY—WEDNESDAY, MAY 9TH.

The Society was opened with prayer by the Rev. Dr. Logan, of Richmond.

The minutes of the previous meeting having been printed and distributed, their reading was dispensed with.

Dr. J. M. Foster, of Richmond, chairman of Committee of Arrangements, welcomed the members of the Society and invited guests in old-fashioned Kentucky style.

The secretary, Dr. Steele Bailey, made his report as follows:

The secretary would respectfully say that, to the best of his ability, he has fulfilled the multifarious and onerous duties appertaining to his office.

The past year has differed from the three preceding ones in which he has occupied his present position in the particular of correspondence, which has been unusually large, not at all burdensome.

The minutes of the last session were sent in exchange to the societies of Arkansas, Tennessee, Mississippi, Louisiana, Vermont, Virginia, Pennsylvania, New York, Rhode Island, New Jersey, Maryland, Nebraska, Michigan, Kansas, Ohio, Georgia, Alabama, Wisconsin, Texas, Connecticut, Oregon, and California. The same compliment was extended to the National Board of Health, and the State Boards of Health of Michigan, Wisconsin, and Pennsylvania.

That part of the minutes containing the second and third sections of the amended act against empiricism arrested the attention of a good many, to whom the statute seemed entirely new. A great many letters from home, besides several from different States, were received, making various inquiries; some asking for the exact construction of the law, others wanting to know how to evade it, and one importunate as well as unfortunate gentleman from Vermont desired to know how he could come to Kentucky (a country he had long had his eye on) and practice physic, saying that he was worthy and well qualified, but had no diploma, and really did not think an instrument of that kind necessary for success in the practice of the medical art. To all these communications I courteously replied.

So far as I have been informed only two members have died during the past year. One, our dear friend John L. Price, of Lexington, January 5th, the other M. E. Poynter, of Midway, on April 25, 1889. Their deaths were deeply regretted and sincerely mourned by the respective communities in which they lived. Both are square on the books, and have always been so. The good they did lives after them; their works follow them.

I herewith submit the financial report for the year ending May 10, 1889, which is accompanied by vouchers wherever possible:

Rec'd at Crab Orchard Springs, July, 1888, \$213 40

#### Disbursements.

Salary of Secretary.....	\$100 00
Amount advanced by him.....	14 50
Amount overdrawn in bank.....	4 50
Morton & Co.....	13 00
Rogers, Tuley & Co.....	1 34
Enquirer, Cincinnati.....	1 50
Courier-Journal.....	9 75

\* Stenographically reported by William Y. Howard, M. D., Louisville, Ky.

Morton & Co.....	\$7 75	
Morton & Co.....	6 50	
Morton & Co.....	4 80	
Stenographer.....	20 00	
H. E. Samuel.....	2 25	
Richards, one-cent stamps.....	6 00	
Wrappers.....	5 00	
Stamps and envelopes.....	6 00	
Postal cards.....	5 00	
	<hr/>	
	\$197 89	
Balance in bank.....	15 51	\$213 40

Conclusion: In the multiplicity of things old truths and old facts are liable to be forgotten, but we may with unction, and without hesitation or mental reservation, aver that the Kentucky State Medical Society has the emblem of progress upon her banner; she is behind no other State medical society in the education, refinement, and culture of her members; the average attendance is as good as that of her neighboring State societies, and she is able to maintain the high position she has attained in the profession of this country.

The librarian, Dr. T. B. Greenley, of West Point, reported that during the past year no books had been contributed.

First paper of the session was read by Dr. J. W. Gilbert, of Lawrenceburg, Ky., on the Progress in Practical Medicine. (See this issue, p. 324.)

#### DISCUSSION.

Dr. J. A. Ouchterlony, having been requested by the president to open the discussion on Dr. Gilbert's paper, expressed hearty commendation of its merit, and said that he would notice especially two points in connection with interstitial nephritis. One is the etiology of the disease, and the other the complications of heart lesions. He said that in his private practice and hospital work he had seen a great many cases. Where it was allowable he never failed making an autopsy, and the result of his observations was the conclusion that the habit of intemperance is the most frequent cause of "chronic interstitial nephritis." By the time of the patient's death, however, he may also be a victim of chronic interstitial hepatitis, both conditions being often produced by the same cause.

An undue amount of alcohol circulating in the blood is competent to produce interstitial changes in the liver and in the kidney, yet cases of chronic interstitial hepatitis have occurred in people who have never tasted alcohol, and we often see cases of confirmed drunkenness in which neither hepatitis nor kidney lesion has occurred. In cases of chronic interstitial nephritis we usually find hypertrophy of the heart, and in these cases the cardiac lesions may be detected early. We may later on have chronic valvulitis, brought about by the manner in which the blood is forced through the aorta and the consequent friction. It may occur in children between the ages of two and ten years, and possibly even earlier in life than this.

*The Report on the Progress of Surgery* was read by W. L. Rodman, M. D., Louisville. (See p. 329.)

It was agreed that this report should be discussed conjointly with the report on Laparotomy for Penetrating Wounds of the Abdomen, by Dr. David Barrow. (See p. 344.)

*Report on the Progress of Public Hygiene*, by J. N. McCormack, M. D., Bowling Green. (See p. 335.)

At the conclusion of his paper, Dr. McCormack offered the following resolution:

*Resolved*, That a committee of three be appointed in each county in this State by the President of this Society to secure the enforcement of the new medical practice act in their respective counties, and that a committee of five be similarly appointed for the city of Louisville.

Dr. Reynolds seconded the resolution, and asked if it was the purpose to impose a duty upon the State Society for securing the enforcement of the laws.

Dr. McCormack: If the treasury is in a fit condition, I think no better expenditure could be made of the surplus.

Dr. Reynolds: Provided that a surplus fund be contributed to that purpose; if I be not mistaken, the by-laws regulate the disposition of the treasury surplus.

Dr. McCormack then stated that he believed the surplus, after defraying all expenses of the Society, was to go to a prize-essay fund.

Dr. Wathen: It does not look well for doctors from Louisville to ask our country friends to contribute money to enforce laws violated in Louisville.

We are now raising funds for the prosecution of the quacks, and in due time able counsel will be employed for that purpose. The colleges are contributing to this end, and with an individual contribution of say five dollars each we can raise the money, and there will be no trouble about their conviction.

Dr. McCormack: Dr. Wathen misunderstood me, Dr. Reynolds' amendment was that the fund should not be used in Louisville alone, but to be used if necessary in any county. Doctors out here are not as well off as doctors in Louisville, and the money contributed should be used throughout the State.

Dr. Dunlap: It is the duty of the commonwealth's attorney to prosecute these charlatans independently of any thing we may say or do.

Dr. Dixon: Registration has made no change in Henderson. Legal authorities state that this law being an amendment, that any man who has been practicing his profession for ten years without a diploma has the privilege of enjoying professional rights with graduates. I know of some who have not been practicing six years, but they have registered and are now in the practice of the profession.

Dr. McCormack: As regards Dr. Dunlap's suggestion, I would say that all the protection the public has ever had has come through the profession, and unless we see to the enforcement of the law it will never be done.

Dr. Mathews moved a vote of thanks to Dr. McCormack for the able manner in which he had discharged his duty.

This was unanimously carried.

*The Report on Obstetrics* was read by Dr. John G. Cecil, of Louisville. (See p. 336.)

#### DISCUSSION.

Dr. A. D. Price said: There is perhaps no subject claiming the attention of this intelligent body more important than obstetrics. It is important, because the life of mother and child are involved; because the happiness and welfare of others depend on the result; because the ills of pregnancy and the dangers of parturition can by due care and careful management be rendered almost nil.

This is a very broad subject, and may be made to cover the entire period embraced between conception and the conclusion of the lying-in state. Pregnancy and parturition require the care and supervision of the medical attendant, that the progress of the one may be unimpeded and the dangers of the other avoided.

I would impress upon all the necessity, nay the importance, of a careful and continuous supervision of the pregnant woman. Her general health should be looked after and kept in good condition by suitable food, out-door exercise, cheerful surroundings, and proper therapeutic measures.

A most important duty in the management of pregnancy is the chemical and the microscopical study of the urine, frequently and often repeated, whereby indications of treatment are obtained not otherwise to be had. Prophylaxis in puerperal albuminuria accomplishes much. The avoidance of excitement, uniform temperature, diaphoresis, diuresis, hydrogogue cathartics properly used, dry-cupping, and especially milk-diet and the administration of iron will often carry the patient safely through this dangerous period.

The pregnant woman is often criminally neglected. She is seldom even in the thought of her medical attendant till he is called to relieve some threatened danger, or to render assistance during parturition. The importance of the supervision of the pregnant woman can not be overestimated, and should be impressed again and again upon physician and patient. The one, and especially the general practitioner, occupied with a multiplicity of responsibilities, often grows careless

and negligent in matters of the gravest importance; the other, ignorant and lacking training in those things of vital concern to her well-being, can not realize the necessity of demanding the care and investigation that her condition requires.

The physician, then, who does not investigate the condition of the pregnant woman and impress upon her its importance fails to properly discharge his duty.

Bad results I know often do not follow this happy-go-easy way common to many practitioners. But it is the blind leading the blind. It is when the signals have not been observed that the storm comes suddenly and unexpectedly. Dangers are encountered that could have been avoided. Forewarned is forearmed, a truth divine which every obstetrician should cherish and religiously observe.

When should the parturient woman have an anesthetic? When her suffering demands it. She should not be terrorized, depressed, and unnerved by pain when it is so easily and safely prevented. Chloral for this purpose is valuable in the first stage, and renders less chloroform necessary during the second, when it is particularly indicated. I have used chloroform almost invariably during a period of twenty-five years and have not seen a case in which it was contra-indicated, or in which it had any bad effects, save occasionally to lessen the pains to such a degree as to require the forceps to complete labor in reasonable time. A fatty heart, if known, is the only condition that would deter me from its use.

When called to the parturient woman it is of the first importance to diagnosticate the position of the child. If the ordinary method does not give positive information, introduce the hand, administering chloroform if necessary, and in this manner acquire the knowledge desired. How often a lingering and tedious labor is the result of some faulty position that could have been easily and readily corrected in the earlier stage! We have all seen such cases, and will doubtless see them again.

The occipito posterior position is one claim-

ing special attention—one easily, unless head is severely impacted, corrected by introducing the hand or applying the forceps in a reversed position and rotating the occiput forward. I have frequently employed these methods and readily completed a labor that had been tedious and threatening in its results.

How long should labor continue is a question that will be asked time and again. It must be solved at the bedside; not as an old medical friend of mine was in the habit of doing, by waiting and hoping, by sympathizing and weeping with the suffering patient and anxious friends, and praying the good Lord to hasten delivery, but by applying the forceps and completing delivery before the vagina becomes hot and dry, and before exhaustion supervenes. Do not wait and hope till tired nature is no longer able to render assistance, and till the patient is on the brink ready to pass over the river into the life beyond. The forceps, properly and wisely used, save many a mother and preserve the life of many a child.

The great question of the day, the one above all others and in which mankind is directly interested, is *aseptic* midwifery, the principles of which should be constantly urged upon the medical man, and by him persistently taught to the laity till every lying-in woman throughout the land has its benign and protecting influences thrown around her.

Antiseptic surgery is daily accomplishing wonderful results, and no less sure, no less certain is aseptic midwifery secured by antiseptic means, laying the foundation, establishing the proper method, and formulating its principles, lasting and eternal, the application of which has rendered the hospital, reeking with foul odors and swarming with germs ready to devour, as well as the palace, safe and secure abodes for the lying-in woman. When it is remembered that most of the ills of the puerperal woman are septic in origin and preventable, the medical man is not at liberty to neglect any method by which such dangers are avoided. Upon him is laid the responsibility, and to him

patient and friends look for wise counsel, judicious advice, and safe guidance. If such is not vouchsafed her, the full measure of medical wisdom has been withheld.

So fixed am I in my belief, so sure of the protecting influences of aseptic midwifery, that I go to the lying-in chamber expecting no fever to follow, and none of the puerperal diseases to jeopardize the life of my patient. I have frequently tested it, and many recent and protracted and difficult cases, such as formerly gave a great deal of trouble and caused much anxiety, have demonstrated its safety and usefulness.

Aseptic midwifery is secured by perfect cleanliness of physician, nurse, and patient. The patient, after the rectum is emptied by an injection, should be bathed from waist down with water and soap, wiped dry, and sponged with a bichloride solution, 1 to 1,000. The vagina should next be syringed with a like solution of 1 to 3,000. The clothing of the patient and bed should be clean, discarding every thing the least soiled.

The nurse as well as the physician should clean nails, scrub hands with water and soap, and then wash them in a bichloride solution, 1 to 1,000, before touching the patient. This method should be repeated whenever the hands become contaminated.

After completion of labor the patient should be washed with water and soap, and sponged with a bichloride solution, 1 to 1,000, injecting a 1 to 5,000 solution into the vagina or within the uterine cavity if the forceps have been used or it has been necessary to introduce the hand into the womb.

Leave nothing soiled about the patient or bed, and apply a napkin wrung out of a bichloride solution, 1 to 3,000. Keep up this method till the bruised or lacerated tissues are healed, and the reward will be a happy result, a speedy restoration. Prevention is worth more than all the efforts to cure.

*A Report on Laparotomy for Penetrating Shot Wounds of the Abdomen* was read by Dr. David Barrow, of Lexington. He reported four cases treated by laparotomy, and discussed generally laparotomy for such injuries.

CASE 1. White male, aged thirty-one, re-

ceived a pistol wound near the umbilicus; the ball entered the abdominal cavity and perforated the small bowel seven times, and wounded the mesentery extensively. Two branches of the mesenteric artery were divided, and hemorrhage was profuse, the patient being in marked collapse before the operation. A median incision was made, and as hemorrhage continued free, the intestines were rapidly delivered and the bleeding vessels caught. The perforations were then closed with the Czerny-Lembert suture and the raw surfaces of the mesentery were sewed in apposition. The intestines were then cleansed with a weak solution of bichloride of mercury and returned to the cavity; the peritoneal cavity was irrigated and sponged. The incision was sutured with silk and antiseptic dressings applied. The operation lasted two hours. Collapse in the patient was the prominent condition, due mainly to the hemorrhage, and he never rallied; death occurred three hours after he was put to bed.

CASE 2. White male, aged twenty-five, was shot at 10 P. M., November 6th, with a 38-caliber pistol; he was drunk at the time. The wound was below and to the left of the anterior superior spine of the ilium, and below the liver; the bullet could be felt under the skin. The ball had traversed the abdominal cavity. Shock was slight and there had been no vomiting. A median incision was made from the ensiform cartilage down; the small intestines were examined and nine perforations found. Six of the perforations were sutured with carbolized silk; the other three being close and destroying a large part of the bowel lumen were resected, about four inches of the gut being cut out; the ends were united with the Czerny-Lembert suture. Before the intestines could be returned to the cavity the gas had to be evacuated by puncture. The incision was hard to close, and strong relaxing sutures were used. Operation lasted two hours; the patient died fifteen hours after.

CASE 3. Mulatto, aged twenty-nine, was shot on December 25th at 10 A. M.; was seen at 2 P. M. the same day; he was

drunk and there was no shock. To the left of the umbilicus was a bullet wound. An incision was made in the median line and the viscera examined, but no injury found. The patient recovered rapidly, and on the twentieth day left for the country.

**CASE 4.** Negro, aged twenty-five, shot 10 P. M. April 22d; seen 2 A. M. the 23d; there was then but little shock. Below and to the right of the ensiform cartilage was a pistol wound. A median incision was made thirteen hours after the wound was received; a quantity of blood and bile escaped. The ball passed through the right lobe of the liver and cut one of the bile ducts; the gall bladder was intact, but empty. The liver wound bled freely; it was plugged with gauze, and the hemorrhage controlled. Operation lasted one hour, and the patient rallied well. For two days he did well; jaundice was then marked and he became restless and delirious. He continued in this condition for five days when he died. There was never the slightest evidence of peritonitis, and death was due to cholemia.

In the general remarks Dr. Barrow said: Dr. Coley in the *Boston Medical and Surgical Journal*, gives to Baudens, of France, the credit of having done the first laparotomy for penetrating shot wounds of the abdomen in 1836. Dr. Kinlock, of Charleston, S. C., did the operation in 1881, and Kocher, of Berne, Switzerland, had a successful case in 1883. In this country Dr. Bull met with the first success in 1884. Dr. Coley in his article collects seventy-four cases with 39.5 per cent recoveries; under the "let alone" management of such cases less than 10 per cent recovered.

Shock is an unreliable symptom, and the absence of it should not deter the surgeon in opening the abdomen; the fact that a ball has entered the peritoneal cavity is sufficient ground for an operation. All of the cases have recovered where the exploration has been resorted to and no visceral injury found. Senn's hydrogen gas test for perforation may take the place of the exploratory operation in great part. The first thing to ascertain in gunshot wounds of the abdo-

men is, whether the peritoneal cavity has been entered, and to do this it may be necessary to enlarge the wound and follow the track of the ball. In operating the median incision will best serve the surgeon; some times, as in the case of Dr. McGraw (wound of the ascending colon), it may be better to enlarge the wound and repair the injury through it. When the direction of the ball is known only those viscera liable to injury should be examined and no others manipulated.

To deliver the intestines and keep them out of the cavity for a long time, even when protected by warm towels, will cause marked shock; and, if possible, only the loop manipulated should be cut, and it should be returned before another is delivered. In hemorrhage the intestines must be delivered and the vessels caught as quickly as possible. When the blood supply to part of the tube is cut off, resection should be done, and in resecting we can use the Czerny-Lembert suture or Senn's modification of Jobert's invagination suture.

The prognosis of uncomplicated wounds of the solid viscera is favorable, more than half of them recover. To stop hemorrhage from the solid viscera a deep suture may be inserted, or if that can not be done, the cautery may be applied, or the wound may be stuffed with gauze, as has been successfully done in a liver wound. It may be necessary to remove the spleen or a kidney if the hemorrhage can not be controlled. Should the gall bladder be injured and the bile extravasated, the prognosis is most grave. Bladder wounds should be sutured.

There has been but one reported laparotomy for gunshot wound of the abdomen in Kentucky, and that was reported by Dr. Isaac Warren, of Somerset. His patient died of peritonitis.

#### DISCUSSION.

Drs. Rodman and Barrow's papers were discussed conjointly, as follows:

Dr. Arch. Dixon, of Henderson said: Gas is of considerable value beyond all doubt, not only as a means of diagnosis, but it

should be used after the operation to see that the gut has been entirely closed. In obstruction of the bowel I was able by means of the gas to find the obstruction, the gut being bound down by an adhesive band, illustrating the value of its employment in these cases.

The treatment of cystitis is most difficult in females, as the drainage is so difficult.

I have used both the free drainage and the catheter, giving the bladder the most necessary of all procedures, rest. In the treatment of aneurisms I agree with Dr. Rodman.

Dr. Ap Morgan Vance, of Louisville: I certainly can't see why we can not open abscesses of the lungs and remove pus when necessary. I am an ether man when it is not contra-indicated. It is the duty of the surgeon to make an examination of the kidneys and lungs before the administration of an anesthetic.

Dr. Vance referred to a case in the person of a boy who was shot in the right loin, the ilium being perforated in eight places; it was sutured, as Dr. Barrow's cases were, but he died four days after the operation, death resulting from the division of the ureter. As regards the hydrogen test, we rarely ever have time to use it unless we take the gas with us. I am of the opinion that more harm is done by waiting than in making an exploratory examination. Where the abdomen is penetrated it should certainly be opened and cleaned.

Cases often die where the wound is outside of the cavity, as the result of abscess formation.

The speaker referred to another case. A boy, seventeen years old, was shot by a penetrating ball. It entered just outside the crest of the ilium, injuring the gut in seven or eight places, and perforating the bladder. The gut and bladder were both sutured. Six hours after the injury he had an injection of morphine and atropia, when the operation was performed; patient died six hours later from exhaustion.

I can't consent to doing median laparotomy in every case. I only do this operation

when the wound is near the median line. The finger thoroughly cleansed makes the best probe.

Dr. A. W. Johnston, of Danville, said: I believe an exploratory incision, promptly and quickly done, does no harm, but prolongation of the operation is the factor productive of most evil.

I saw a negro man, shot in the service, in the very room where Ephraim McDowell did his first operation; but the poor fellow was in such a wretched condition, and, as I thought, was so soon to die, that an operation was not attempted. He, however, rallied and made a full and complete recovery.

Pure healthy bile, left of itself in the peritoneum, I don't think does much harm. I believe that catarrhal mucus is the causation of the trouble. The best time for the use of hydrogen gas is after the stitches have been put in the abdomen and before they are tied.

Dr. J. N. McCormack: After an experience involving two resections of the bowel, I think too great an attempt is made at what might be termed "mechanical exactness" in suturing, which results in allowing exposure of the gut for too great a length of time. If there is any sort of apposition, pressure upon the abdominal walls will sufficiently close the wound to secure perfect union. The surgeon should not attempt to close it as the glover would stitch his glove, he should remember that he has vital parts to deal with.

Dr. C. Skinner, of Louisville, said: The incisions should always, if possible, be made in the median line, here the belly wall is thinner and easier to get through. Should you have an injury of the liver, however, the case is altered. In the median-line operations we can irrigate and return the bowels with much more ease.

Dr. Barrow said that his patients had been moved too much, and that this encouraged the extravasation of fecal matter from the bowel into the cavity. After entering the cavity we should secure the bleeding points before searching for the perforations in the bowel. Lembert's suture is the eas-

iest to apply. Hot-water irrigation is the best. I think more trouble has resulted from probing than any other cause. When there is any doubt of perforation do your laparotomy; do it early; then try your hydrogen test, search the bowel, be sure you have an abundance of light, and find all possible openings.

Dr. L. S. McMurtry, of Danville, said the great danger to the patient, after a gunshot wound of the intestines, is from hemorrhage and shock. This fact makes it very important to operate early and to execute the operation with dispatch and promptness. I am sure that in these cases we keep the patient on the table too long. Time is consumed in elaborate preparation, the patient and friends often delay operating, and, as Dr. McCormack has stated, too much time is consumed in mechanical exactitude in suturing. In a case of perforation of the intestine, treated by laparotomy and suture of the openings in the gut, reported by me last year, I am satisfied that my success was due to the early acceptance of the operation by the patient and its prompt execution. That case also illustrated the fact that it is best to select the site of the incision in view of the seat of the lesion. The lesion was evidently in the right iliac fossa and the incision was made over the tumor. If made in the linea alba the difficulties of the operation and drainage afterward would have been less efficient. The shock is often increased by prolonged anesthesia. The patient should not be anesthetized until the surgeon is ready to operate. A few weeks since I saw a case of laparotomy and excision of the pylorus for cancer at Billroth's clinic in Vienna, where I am sure whatever chances of recovery the patient had were materially impaired by the prolongation of the operation. The patient was on the table near three hours, and less exactitude in suturing would have economized time with great advantage.

I am convinced that in suturing the gut for gunshot wounds, as in other abdominal operations, silk is the best material for sutures.

I heartily concur with the views given by Dr. Rodman and Dr. Barrow upon the duty of giving every possible case the chance afforded by the operation. It is also our duty to open the abdomen at once in all penetrating wounds to determine whether or not the intestines are injured, to see if blood is effused, and to cleanse the peritoneum. An exploratory incision is preferable to Senn's method in diagnosis of these cases, from the fact that whether the intestine is opened or not, the hemorrhage is arrested and the peritoneum cleansed. Before closing the abdomen the gas will do a great service doubtless in deciding if all openings have been found and closed.

Dr. Larrabee mentioned the non-surgical parts of the operation: the death from chloroform and the uses of iodoform. In most cases he had observed or heard of death occurred during the first few whiffs of the anesthetic. He could not see how there could have been saturation of the system. Ether is always attended by tetanic symptoms. Give it as freely as possible. Many deaths from chloroform are not due to faulty administration, but to chlorine in the chloroform. Operations of minor importance should never be undertaken until the patient is fully under the anesthetic. I have seen three deaths resulting from the excessive use of iodoform.

Dr. Rodman, closing the discussion, said: I was not able to cover all the ground in surgery; I only mentioned those new things which have occurred during the year. In chloroform administration the danger is proportionately great as regards the toxic influence of the drug; in those who die, death is generally due to spasm of the glottis. Dr. Larrabee's point is well taken. A great many deaths have been reported from the excessive use of iodoform. I agree with Dr. McMurtry that silk should be used in all abdominal work. In thirty-two cases reported by Sir William McCormack, where the ligature is specified, he mentioned silk. I think Dr. Dixon's point, that we should use the gas after rather than before the operation, is faulty teaching. We should be

prepared and have the gas on hand for constant use. It may be well to use it after the operation; but it is of great value primarily.

Dr. Barrow, in closing the discussion of his paper, stated that absorption of bile was the cause of the death of one of his patients, and not an intercurrent peritonitis. He does not see why a clean aseptic probe can do more harm than a finger.

The Society had a special session in the evening, the address of the president, Dr. L. S. McMurtry (see p. 321), and an address on The Relation of Medicine to the Other Sciences,\* by Dr. John A. Ouchterlony, being the order of exercises.

[TO BE CONTINUED.]

## Abstracts and Selections.

**OPERATIONS ON THE TARSUS IN CONFIRMED FLAT-FOOT.**—A patient with flat-foot applies for relief, not for objective symptoms, but for the subjective one of pain; and this relief can almost always be given by means other than operative.

In determining the employment of "tarsotomy" and "tarsectomy," I clinically regard these flat-foot cases as forming several cases—not grades; for one does not seem merely to be an exaggeration of the other, but presents different symptoms. In the mildest form there is mere flatness with eversion and no pain. This condition hardly calls for treatment. There is a class in which the objective and familiar symptoms are all present, and also pain, which for the most part is beneath the external malleolus; but this pain is not severe, and it only comes on after much standing, and the ankle-joint movements are free. Mechanical means, with rest, will remove all the subjective symptoms, though the deformity may remain practically unaltered. In another class, superadded to this condition is that of rigidity from spasm of the muscles round the ankle; and this joint is absolutely fixed, save during sleep, to all attempts at movement, both active and passive. It forms a definite class of cases, which I have termed "valgus, with fixed foot." The bone deformity in this class may be slight or severe, but the eversion is well marked; yet in my experience these cases do not call for osteotomy, or even (save quite rarely) for tenot-

omy; complete relief can be given by other means. There is yet a class in which not only may all the before-named symptoms be present, but the arch is so badly fallen that a convexity rather than a flatness takes its place, due to two tubercles projecting downward—the scaphoid and the head of the astragalus. Along with these objective symptoms there is a most wearying and constant aching under the external malleolus, whether accompanied or not by other pains about the ankle. The pain is always present on standing, and after a few hours it becomes a physical impossibility to stand any longer. Now an external malleolar pain is common to all flat-foot cases, and is most marked where eversion is best declared, and it is due to the crowding of the tissues against the outer malleolus from the malposition of the tarsus. If the foot is returned again to the normal line of the leg, the patient stands without pain; but in these worst cases that I am referring to the extreme pain is not thus easily relieved. A deep-seated aching still incapacitates the patient, whatever the position of his foot; it is due, I believe, to a special cause. It depends upon the fact that, since the arch of the foot is sunken and its piers are now wider apart on the inner side of the foot, a corresponding crowding or mutual pressure of the bony structures forming the outer or supporting edge of the sole takes place, which mere reposition of the foot will not improve. The extent of this compression along the calcaneo-cuboid bony line may be judged of by a measurement taken along the *inner* edge of the foot. In the normal foot the tarso-metatarsal joint of the great toe is the exact middle of the edge; and since the arch lies practically behind this point, the excess of measurement of the posterior half of the foot over the anterior shows the extent to which the arch is sunken, and the astragalus as a wedge becomes jammed down toward the sole. In a young adult foot, in which the anatomical anterior half measures four inches and three quarters, the posterior half will in a bad case measure five inches and a half, or three quarters of an inch more than normal.

It may be here pointed out that strictly the only rotation of which a foot is capable is at the metatarsal (Chopart's) joint, and if the anterior half is rotated outward the condition is one of varus; if inward (or toward the sole), it is one of valgus. The ankle-joint itself allows only a hinge movement; but in flat-foot—and valgus can not exist without it, nor the reverse, and hence

\* Dr. Ouchterlony's address will appear in our next issue.

valgus and flat-foot are clinically synonymous—the sinking down of the astragalus is, in other words, a yielding of the strong astragalo-calcaneal interosseous ligament, whereby the whole foot, save the astragalus, becomes everted; and the scaphoid being advanced from its normal position, the outer line of bones, as already mentioned, suffers compression and severe pain.

It is in these cases, if any, in which tarsotomy in some form is called for; and it is in four such, in the years 1878–80, that I operated. All were between twelve and seventeen years of age, and had histories varying from two to five years. In two the scaphoid alone was removed, and in two that bone and the head of the astragalus; the idea being to remove the wedge on the inner side, which caused the pain on the outer. In all the steps of the operation were the same, and the results uniformly good, three of the patients being up within the month. All were cured of pain, but in only one was the arch really restored. It was in one in which, besides removing the scaphoid, I sawed subcutaneously across the whole tarsus; by this means it was easy, on a suitable splint, to adduct and rotate the foot upon the back part of the foot; and though the same splint was employed in all the cases, yet in three of them, because of the integrity of the outer border of the tarsus, apposition of the cuneiform and astragalus on the inner side could not be maintained. By ablation of bone, together with a true tarsotomy, the restoration of the arch, if desired, can be assured, and the use of pegs to unite the sides of the wound in the tarsus will be quite uncalled for.

These four cases on which I operated came before me in the course of fifty consecutive cases of flat-foot, which would give a percentage of eight for operation. But in the last eight years I have not seen a case demanding operation, and one which I could not cure by non-operative means; so either my percentage reads too high, or, what is nearer the mark, I think that I have been able to adapt in an increasingly effectual and practicable manner to all sorts and conditions of patients the principle of the elastic spring dressing introduced years ago by Mr. Barwell.

Operation has been advised and employed on yet another class of valgus cases from a mistaken diagnosis. They are cases which I have termed "arthritic valgus," the flat-foot causing and being accompanied by osteitis, swelling, and pain of the ball of the great toe. In the young I have known resection

of the joint and even a Chopart's amputation performed; in older cases prolonged anti-gout treatment has been ineffectually persevered with. I have never yet seen a case of arthritic valgus in which the arthralgia and arthritis could not be cured by rest and mechanical means. In a word, I would confine operation on the tarsus to those valgus cases in which not so much the deformity as the pain is the symptom which incapacitates the patient, and then only after a fair trial of rest followed by suitable appliances. Paradoxical though it sounds, it is none the less true that cure can be accomplished without the restoration of the arch; yet, in a case in which operation was considered necessary, I should not be content with mere division of the tarsus or with mere ablation of the keystone of the arch, but with the latter combined with the former, whereby, without in any way adding materially to the difficulty of the operation, the divided parts on the inner edge of the foot may be easily brought into contact with each other without pegging, and the arch of the foot restored, and so a more perfect return to the normal state of the foot be insured; although, as stated, a mere bone ablation suffices to cure the pain, the deformity remaining to all appearances the same.—*C. H. Golding Bird, M. D., F.R.C.S., London Lancet.*

**PRECANCEROUS CONDITIONS OF THE TONGUE.**  
Mr. Butlin (Harveian Society of London), in his paper on this subject, dealt chiefly with three points: (1) The proportion of cases of cancer of the tongue in which the disease was preceded by a well recognized cancerous condition. (2) The relative importance of various precancerous conditions. (3) The question of the early and free removal of some precancerous conditions. In a certain number of cases which had been under the care of the author, cancer of the tongue had been preceded by a precancerous condition in at least seventy per cent. Warty growths appeared to be the most dangerous of the conditions which actually and immediately preceded cancer, and these warty growths were shown to be more frequent than was generally believed. The question was raised whether it would not be right in cases of leucoma and chronic superficial glossitis, in which warts and warty growths form on the surface of the tongue, to remove the whole of the diseased area of the tongue, or certainly the firm part of the organ, instead of merely removing the warty growth and an area of the surround-

ing tissue. Two cases were related in which simple warty growths formed on leucomatous tongues and were removed, and in which, at a later period, cancer developed, but not in the seat of the removal of the warts. The use of liquor arsenicalis internally was recommended in all cases of chronic affection of the surface of the tongue in which the disease was associated with various forms of chronic affection of the general integument (non-specific). Several cases were related to show the advantage of the removal of early cancerous affections of the tongue.—*British Med. Journal*.

**EPILEPTIC AURA.**—Dr. A. Hughes Bennett, after a careful study of the sensory aura of epilepsy (*London Lancet*), arrives at the following conclusions: (1) In a given series of cases of epilepsy or of epileptiform attacks there are a certain percentage in which a pronounced feature consists of an aura of one of the special senses. In 500 cases there were in round numbers an aura of the sense of touch in 10 per cent, of sight in 3 per cent, of hearing in 1.5 per cent, in smell in 0.75 per cent, and of taste 0.75 per cent. (2) These aura take the form of the development of crude subjective sensations of one of the special senses, and consist of a sudden attack of exaggerated sensation of pain, light, noise, smell, or taste. (3) These exaggerated sensations of sense are immediately succeeded by the opposite condition—namely, by a temporary abolition or diminution of the special sense previously affected, which results in anesthesia, amblyopia, deafness, loss of taste, and anosmia. (4) These facts seem to indicate that each of the special senses is separately represented in the cerebral cortex, and that each of them is liable to disease. When by irritation they are in a hyper-physiological condition, they discharge their respective functions, the result being a crude subjective sensation of the corresponding sense. When destroyed or exhausted, the function is abolished or temporarily depressed. (5) The sensory cortical centers thus obey the same general laws in their relations to disease as do the motor cortical centers.

**TREATMENT OF INEBRIATE WOMEN.**—Mrs. L'Oste gave a summary (*Society for the Study of Inebriety*) of twenty-seven years' experience in the treatment of cultured female inebriates. The "tapering off" process had proved a failure, and immediate abstinence had been effectual and safe. At first both sexes were treated, but experience soon showed that homes for ladies and gen-

tlemen should be separate. Inebriety was a disease often hereditary, and the germs frequently noticed in children. When not inherited, obstetric troubles were the chief cause of the disease. Fashionable pick-me-ups, reputed non-spirituos, but really intoxicating, were a common cause. While under the influence of the disease the sufferers were not responsible for their actions, and sometimes the crave was irresistible. A special study of each case was needed, with remedial treatment of the predisposing cause. The disease was curable, and the patient must be encouraged to co-operate in the treatment. Women who had felt degraded, when told that they were subjects of a disease, plucked up courage and cherished the hope of cure. Unconditional abstinence was essential, and from one to two years were generally required. The study of inebriety was making great strides, and there was urgent need for governmental free homes for the indigent, who were now wrongly punished as criminals. Mrs. L'Oste had found about thirty per cent were permanently cured, the patients having belonged to the cultured and wealthy classes. *British Medical Journal*.

**PSEUDO-TABES OR PERIPHERAL NEURITIS.** Mr. Pryce showed (*Nottingham Medico-Chirurgical Society*) a case of pseudo-tabes or peripheral neuritis in a man, aged thirty-five. There was a history of so-called rheumatism attended by pains and loss of power in both upper and lower extremities four years ago. Gradual recovery followed until one year previous to coming under treatment, when the same symptoms were again experienced. The symptoms of the case were the following: (1) Sensory phenomena in the form of pains varying in character, slight anesthesia over the anterior aspect of both ankles, and considerable delay in the transmission of sensory impressions; (2) motor symptoms, as shown by paralysis of the extensor muscles of the leg and consequent foot-drop; muscular wasting, but no tenderness; (3) abolition of the knee-jerks, and the impairment of the superficial reflexes; (4) muscular inco-ordination and consequent ataxia. Mr. Pryce described the characteristics of the disease as distinguished from tabes dorsalis proper, and pointed out that while diseases due to peripheral neuritis were frequently curable, tabes dorsalis was almost invariably incurable. The patient had suffered from syphilis, and treatment by iodide of potassium was followed by considerable improvement.—*Ibid*.

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## KENTUCKY STATE MEDICAL SOCIETY.

The recent meeting at Richmond was of more than common interest. During the working sessions good grist in full measure pressed the hoppers, and the proceedings show that it was well ground. Beyond the reading and discussion of the regular papers, there was little to engage the attention of the Fellows in the assembly hall. A few resolutions relative to the execution of the existing law for the suppression of quackery in the State, and the regulation of pharmaceutical practice in the small towns, were discussed and adopted; but the politics of the Society proper were wisely not suffered to parade in open session.

It would seem that our friends in Richmond out-Kentuckied Kentucky in the matter of welcome and good cheer, having by common consent succeeded in making every moment of every delegate and visitor's sojourn in that historic town as delightful as a dream of fairy land.

In the election of Dr. John A. Ouchterlony to the presidency, the Society pays fitting compliment to the profession in Louisville, and does itself honor. Under his able administration the success of the coming meeting at Henderson is assured.

Elsewhere in this issue will be found a report of the proceedings of the first day, with the address of the president, and four of the papers read. This, with our next and subsequent issues, will lay before our readers a complete report of the Society's proceedings, with the full text or an abstract of every paper read.

We here express our best thanks to the Fellows for the good number of papers and abstracts received.

## AMERICAN SURGICAL ASSOCIATION.

At the regular annual meeting of this society the senior editor of this journal was elected president for the ensuing year. Fifteen years ago Dr. Yandell was called to like office in the American Medical Association. He is, therefore, after the late Dr. Samuel D. Gross, the only man who has been honored with the presidency of the two representative bodies of American medicine and American surgery. This is matter for more than common gratulation, and if his honored name were not at the head of this page the junior editor would have his say about it. As it is, his pent enthusiasm must find vent through other channels.

## PROF. GROSS' SUCCESSOR.

Dr. W. W. Kean, of Philadelphia, has been called to the chair of Surgery in Jefferson Medical College left vacant by the death of Prof. Samuel W. Gross. It is said that a better selection could not have been made, since Dr. Kean is known to be learned, brilliant, and skillful in all that pertains to the science and art of surgery.

THE TEXAS MEDICAL ASSOCIATION has just concluded at San Antonio one of the most successful meetings in its history. Dr. J. R. Briggs, of Dallas, editor of the Texas Health Journal, has again secured the prize of one hundred dollars in gold for the best essay. He has our hearty congratulations. The next meeting will be held at Fort Worth.

## Notes and Queries.

**TENNESSEE STATE MEDICAL SOCIETY.**—The Tennessee State Medical Society met in its regular annual session at Nashville on April 30th, May 1st and 2d, with the president, Dr. T. J. Happle, of Trenton, in the chair, and the secretary, Dr. D. E. Nelson, of Chattanooga, at the desk. The treasurer reported \$169.68 in the treasury. Much attention was paid to legislation, and it was reported to the Society that, as the results of forty years' labor, the legislature had at last been persuaded to pass a law regulating the practice of medicine. Though this was far from perfect, yet it was a great gain, and all should give it their hearty support. The following gentlemen were recommended to the Governor for appointment as a Board of Examiners: Drs. C. Deadrick, Knoxville, J. B. Murfee, Murfreesboro, and D. D. Saunders, Memphis. A resolution requesting the legislature to pass the bill now pending requiring the registration of births and marriages was passed. Election of officers resulted as follows: Duncan Eve, Nashville, President; Drs. Henry Berlin, Chattanooga, James B. Neil, Marshall, and J. P. C. Walker, Dyersburg, Vice-Presidents; Dr. E. D. Nelson, of Chattanooga, Secretary, and Richard Cheatham, of Nashville, Treasurer. The next meeting will be held at Memphis the second Tuesday in April, 1890. A full programme was presented.

**ELECTRICITY FOR SNAKES.**—A report comes by way of Germany that a novel use of electricity has been made in India, for the prevention of the intrusion of snakes into dwellings. Before all the doors and around the house two wires are laid, connected with an induction apparatus. Should a snake attempt to crawl over the wires he receives a shock of electricity which either kills or frightens him into hasty retreat.

The Philadelphia Medical Times, the Medical Register, and the Dietetic Gazette have united, and will hereafter be published as a weekly, devoted to general medicine, with a

quarterly devoted to dietetics. The Journal will be under the charge of Dr. William F. Waugh. It will be practical in character, and devoted to the interests of practitioners. Dr. Waugh has been in the editorial harness for over four years—first with the Medical World, then with the Philadelphia Medical Times, which he has edited since October, 1887. The editorial labors will be shared by the members of the American Medical Press Association, under whose auspices the Journal is issued.

**TOBACCO AGAIN.**—It is said that ten out of twenty candidates for cadetship at West Point were recently rejected on account of tobacco heart brought on by cigarette-smoking.

The legislature of Massachusetts has appropriated \$55,000 for the purchase of land and the erection of buildings for an epileptic hospital at Baldwinsville.

The American Association for the Advancement of Science meets at Toronto, Canada, August 27th, and will remain in session until September 3d inclusive.

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## SPECIAL NOTICES.

*Messrs. Reed & Carnrick:*

GENTLEMEN—It gives me pleasure to say that I regard your Food Preparations *far superior* to all others. I can point to many little ones whose lives, I feel confident, were saved by them. I have been practicing medicine in Texas for twenty-two years, have tried many other preparations, but after all I hold to yours as the old reliable; they have never disappointed me. My motive in making this statement is that others may be induced to give them a fair trial. Yours truly,

J. L. CUNNINGHAM, M. D.

DALLAS, TEX., June 5, 1888.

**CHRONIC PULMONARY CATARRH.**—J. S. Swain, L.K.Q.C.P. and L.R.C.S., 37 Park Lane Terrace, London, England, says: "I have used S. H. Kennedy's Extract of *Pinus Canadensis* in the following case: Mr. C., aged about thirty-five, suffering from chronic pulmonary catarrh, with pain in left side and great expectoration, cough paroxysmal and lasting some minutes; gave Extract *Pinus Canadensis* internally; after second bottle the expectoration was less, pain in side left, and felt more in throat, and he coughs less and feels better in himself."

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÂ."

VOL. VII.  
[NEW SERIES.]

LOUISVILLE, KY., JUNE 8, 1889.

No. 12.

*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.*—RUSKIN.

## Original Articles.

### REPORT ON OPHTHALMOLOGY.\*

BY S. G. DABNEY, M. D.

*Professor of Physiology, and Clinical Lecturer on Diseases of Eye, Ear, and Throat, in the Hospital Medical College of Louisville.*

During the past year the advance in ophthalmology, though marked by no brilliant discovery, has been steady and uniform, and has consisted chiefly in retaining what was good and rejecting what was undesirable in former methods.

The operation for the removal of cataract must always be ranked among the most important of the oculist's surgical procedures. The past few years have brought about several changes in the method of extracting cataract; many ophthalmic surgeons now perform the operation without iridectomy, the so-called simple extraction. The statistics of Knapp, Bull, Webster, and many others, show that in the hands of the most practiced and expert this procedure may be followed by results as good as were obtained by the combined operation; but the fact that, at the International Ophthalmological Congress of 1888, only five out of two hundred and fifty members warmly advocated extraction without iridectomy, shows that this mode of operation is as yet very far from general adoption by the profession, and that it is as yet quite impossible to speak positively as to its advantages in the hands of the average oculist; it seems prob-

able, however, that the operation with iridectomy will continue the safest and most satisfactory for most cases of cataract extraction by the surgeon of ordinary skill. Another innovation, and one which promises to save the patient much tedious delay, and, it may be, uselessness in the world, is to operate when sight has become greatly impaired, even although the so-called ripening of the cataract, that is, the total opacity of the lens, is not yet complete. According to Dr. Noyes, of New York, the cataracts most suitable for early operation are those of a dull smoky or deeply yellow color, not marked by striations of opacity and clear substance, and which cause a very irregular refraction in the eye; while in that variety of immature cataract in which the cortical layers have begun to disintegrate from shrinking of the nucleus, and in which there is a deeper opacity with intervening clear spaces, it is best to hasten the ripening by a preliminary iridectomy and massage.

The value of antiseptics in ophthalmology, as in other departments of surgery, grows in appreciation every year, but as to the agents most suitable for use in the eye there has been some change of opinion. Knapp, whose great experience entitles his opinion to a high respect, having found the bichloride of mercury, even in a strength of only 1 to 10,000, occasionally irritating as an intra-ocular injection, has abandoned its use altogether, and generally applies a three-per-cent solution of boracic acid, which should be lukewarm. Noyes also cautions against the corrosive-sublimate solution on the ground that it is liable to cause some corneal opacity when the epithelium is desiccated by cocaine, and he too has found a solution of boric acid equally efficient as an

\* Read at the May meeting of the Kentucky State Medical Society, Richmond, 1889.

antiseptic. Brudenel Caster, too, finds mercurial antiseptics too irritating for use in the eye, and recommends a fifteen-per-cent solution of boroglyceride.

As to glaucoma, little has been added to our knowledge the past year. Dr. Theobald, of Baltimore, advances the theory that that form of corneal astigmatism in which the curvature of the horizontal meridian is greater than that of the vertical is a predisposing cause of the disease. At the International Congress, last summer, Priestley Smith presented quite fully his views on glaucoma; but, as they were mostly a reiteration of those he had already advanced, they need not be reviewed here. In the discussion that followed little that was new was elicited, and iridectomy, sclerotomy, and myotics each had their advocates.

Membranous opacities of the vitreous humor are among the most unsatisfactory conditions the oculist is called upon to treat; not only do they greatly impair sight by the obstruction they present to the light reaching the retina, but by their subsequent contraction they are likely to produce retinal detachment. Internal medication is of little or no service. Recently Dr. C. S. Bull has reported a number of cases in which he needled such opacities in a manner similar to that described by Græfe. Cocaine was employed, and a discission needle or slender cataract knife was introduced just in front of the equator of the eye and beneath the internal or external rectus, according to the situation of the opacity as revealed by the ophthalmoscope. Care must be taken to introduce the needle posterior to the ciliary processes, and to avoid any undue pressure on the eyeball by the forceps which are used to rotate it inward or outward, as the case may be. Ordinarily no unpleasant reaction followed the operation, and in nearly all the cases great improvement in sight was obtained. Since the publication by Dr. George T. Stevens, a few years ago, of his article on Anomalies of the Ocular Muscles, their Results, and Treatment, much interest has been felt by oculists and the profession generally in

this subject, and we have looked hopefully for the confirmation by others of Dr. Stevens' views. It must be confessed, however, that the same results have not usually been achieved as were obtained by Dr. Stevens. Dr. Webster, after reporting forty cases of tenotomy for heterophoria, comes to the following conclusions: "That no person should have a tenotomy done for heterophoria without inconvenience probably due to it; very slight degrees may cause trouble and should be attended to; all other methods should be tried before tenotomy." Although it seems that the opinion of Dr. Stevens has been somewhat biased by his enthusiasm, the profession is certainly indebted to him for much zealous work on the muscular anomalies of the eye and the nervous conditions which they may produce. So long, however, as our knowledge as to the conditions is in its present unsettled state, it would seem that the attempts of Dr. Amidon to distinguish between headaches and other neuroses due to the external muscles and similar affections due to refractive errors, according to the locality of the pain, must be rather fanciful.

The importance of correcting optical defects for the relief of many neurotic conditions is an oft-told tale. Every year the journals both of ophthalmology and those embracing all departments of medicine contain the record of many disturbances relieved by the adaptation of proper glasses. At the meeting of the British Medical Association, in August last, Dr. Hewetson presented a paper on General Neuroses Having an Ophthalmic Origin, in which he called attention to the relief not only of the more frequent supra-orbital headache, but also of neuralgia in the back of the neck, insomnia, and vertigo, by the correction of an optical defect. Cases more or less similar must be of frequent occurrence in the practice of every oculist, and certainly most gratifying results are often obtained. When we read, however, such a paper as that presented by Dr. Chisolm at the American Medical Association, in Cincinnati, entitled "The Fourth Dioptric Cylinder the Most Useful

of the List of Cylinders," and observe the number of such very weak glasses prescribed by the essayist, we can not but recognize a tendency to that polytherapy which Landolt in his admirable work cautions us against.

Intra-ocular examination is sometimes of great service in affections of the cerebrum. In brain tumors there is very often a choked disc; and from the analysis of ninety-eight cases Edmunds and Lawford (in *Ophthalmic Review*) found neuritis in eighty-six per cent of cases of tumor at the base of the brain, and in only forty-six per cent in tumors near the convexity. When there are symptoms of meningitis, the presence of an inflammation in the optic nerve is strongly confirmatory of this diagnosis; but, as most cases of meningitis do not show optic neuritis, the absence of such condition is not significant.

Cocaine may be said to have fairly held its own during the past year in its application to ophthalmology; operations on the eyeball, enucleation alone excepted, may almost invariably be performed more satisfactorily with its aid than under general anesthesia, notwithstanding its desiccating effect on the corneal epithelium alluded to above. Its long-continued use, however, has been found by numerous observers to be followed by a form of conjunctivitis similar to that induced by the too protracted application of atropia. The conjunctiva is studded with semi-transparent follicles, the size of a millet seed, or larger, and resembling sago grains. Among the new remedies for which a place in ophthalmic practice has been claimed is creolin. In a one-per-cent or two-per-cent solution, Dr. Adolf Alt has found it a very valuable antiseptic both for cleansing instruments and application to the eye prior to operation, as well as a remedy of great service in interstitial and other forms of keratitis. It is, however, acutely painful when applied to the conjunctival sac, and this fact, together with the conviction that other remedies are equally efficient and less disagreeable, has deterred me from any considerable use of it.

The importance of the papillary reactions as an aid in the diagnosis of diseases and injuries of the nervous system form an important link in the chain which connects the neurologist and ophthalmologist. At the last meeting of the Society I presented a paper on ocular paralysis, in which some cases were reported where the first warning of grave affections of the nervous system was found in the eye. Among the chief contributions to the recent literature of this subject is an article by Hutchinson, jr., in the *Ophthalmic Review*, on *The Pupil Symptoms Met with after Injuries to the Head*. He comes to these conclusions: "In most cases of concussion of the brain the pupil reacts slowly for a certain time, the length of which depends on the severity of the injury, without either marked myosis or mydriasis. In only a few cases there is mydriasis at times—in one eye or both. In inflammatory symptoms, after injuries of the brain, myosis is the rule: in pressure to a meningeal hemorrhage there is generally collateral monocular mydriasis, then binocular."

Toxic amblyopia, of which the special characteristic is central scotoma for colors, has been the subject of discussion by British ophthalmologists.

Nettleship is of the opinion that tobacco is the essential cause, and relates cases to show that improvement may take place, though alcohol is continued, if tobacco be stopped. Amblyopia is generally due to the use of tobacco for many years, but may be caused by very small quantities; it implies probably an idiosyncrasy of the nervous system. Hutchinson, in his brochure entitled *The Pedigree of Disease*, also holds that tobacco amblyopia is attributable to personal idiosyncrasy, and that very small quantities of tobacco may produce it.

To the pathology of albuminuric retinitis Dr. John E. Weeks has recently contributed a valuable article. From pathological and clinical studies he makes the following deductions: "That in regard to their etiology two classes of retinal disease are included in the present acceptance of the term, albu-

minuric retinitis; one depends almost entirely on the condition of the blood brought about by an acute disease of the kidneys, the kidney symptoms preceding the change in the retina, the other depending on a general (systemic) diseased condition of the arteries, capillaries, and to a less extent the veins, in which the ocular changes and symptoms may and not infrequently do precede the kidney symptoms. To the first belongs the retinitis of pregnancy, scarlet fever, diphtheria, etc., and all forms of acute diffuse nephritis, forms usually accompanied with general anasarca. In these cases edema and white plaques precede the hemorrhages. To the second class belong the cases in which the first retinal change is a hemorrhage, or a few small hemorrhages usually in the vicinity of the macula. Contemporary with, preceding or following the hemorrhages in the retina, we may find evidences of capillary hemorrhages in other parts of the system, as in the cord, brain, from mucous membranes, etc. Anasarca is seldom a very marked condition in this form of disease. The first may be termed an irritation nephritis, due to the effect of a morbid element on the kidney tissue, in which the kidney usually becomes enlarged and the circulation interfered with by pressure on the vessels from the swollen tissue; the latter a strangulation nephritis, in which the blood supply is cut off by arterial stenosis, the kidney being always found contracted, and in which morbid element contained in the blood causes a thickening and degeneration of the walls of the vessels with a diminution of their lumen. Both conditions may exist at the same time in varying degrees."

Dr. J. L. Chisolm has reported a case of varicose tumor of the lower lid, which was permanently cured by passing through it a silk seton from the external to the internal canthus, and a few days later bringing the anterior and posterior surfaces of the sac closely together by sutures through the lower lid from the conjunctival surface outward. Dr. Chisolm calls attention to the light thrown upon the pathology of varicose

veins by this case; the constant pressure of a column of blood had no part in its formation; the position, a horizontal vein, was not one which gravitation alone could influence, nor could any straining act induce it. The only explanation for its formation was in a primary change of the coats of this short piece of a small vein, diminishing its elasticity and permitting distension under favorable circumstances. This observation is of the more importance in view of Dr. Chisolm's having been long a distinguished general surgeon before he confined himself to the special province of ophthalmology.

LOUISVILLE.

### TRAUMATIC TETANUS.\*

BY R. C. M'CHORD, M. D.

My object in bringing to your consideration to-day the subject of acute traumatic tetanus is not to discuss its etiology, but rather its treatment, and to propound the question, whether or not we are too much accustomed to look upon it as an incurable disease, and then, folding our arms in its presence, let our patients die without making a fight for their preservation.

In searching the literature of tetanus we are confronted with the overwhelming and prevalent idea that acute traumatic tetanus is incurable. Even the great and learned Dr. Gross, in summing up his ideas as to its prognosis, says: "I have an experience of forty years; I have never seen but three cases where the patient escaped with his life, and then after a protracted and painful struggle."

Did time permit I might go on and cite many similar opinions from those high in authority, going to show how little faith the profession at large have in the therapeutic medication of tetanus.

My experience, though in a small way, has taught me to believe that it is curable; and one of the great essentials to that end is the necessary belief in its curability, and the vim to go in and win irrespective of the prognosis of others. If any one should believe that it is a light task to pilot a case of

\* Read at the May meeting of the Kentucky State Medical Society, Richmond, 1889.

tetanus to a successful termination, I beg that he will disabuse his mind of such a belief immediately, for it is no easy matter, I assure you.

Two years ago, at the meeting of the American Medical Association at Chicago, I had the honor of reporting to the Surgical Section of that body four cases of acute traumatic tetanus, all that had come under my observation and treatment. I felt that they were cases of no little importance, in view of the fact that three of the four recovered. In that report I gave a detailed history of each case and its treatment. This report was published in the *Journal of the American Medical Association* of July 6, 1887, vol. ix.

In order the better to be brief and to further a clear understanding of my mode of treating traumatic tetanus which to-day I would advocate, I will give a brief summary of these cases and their treatment, referring for a more extended report to the journal before mentioned.

**CASE 1.** A stout negro man, aged twenty-one years, had tetanus, the result of a gunshot wound of index finger, received five days previous. Chloroform was administered to its full surgical effect, and then, when the effects had passed off sufficiently for him to swallow, thirty-grain doses of bromide of potash were administered every two hours, the chloroform being given to relax the spasms sufficiently for him to swallow. This was kept up for a few days, until sufficient potash had been given to keep down the tetanic spasms, when the chloroform was discontinued. The potash was continued in thirty-grain doses every two hours for ten days; once only after the third day did I have to resort to the chloroform, and then it was only when the bromide had been left off to test the effect. The hand was dressed for the most part with a flaxseed poultice, and nourishment administered in a fluid form at regular intervals. He made a complete recovery, without any unfavorable symptoms from the heavy doses of the bromide of potash.

**CASE 2.** T. R., negro boy, aged ten years,

stout and well nourished. Tetanus, the result of rusty-nail wound of the plantar surface of the foot. This wound had been received five days previous to the appearance of the tetanic spasms. Chloroform and the bromide of potash in ten-grain doses every two hours was given, as in Case 1, until the morning of the third day, when the tetanic symptoms were under control and the chloroform was no longer needed. The bromide of potash in ten-grain doses was kept up at intervals of two hours for the next three days, during which time he took liquid nourishment with but little difficulty, and only showing tetanic spasms when disturbed.

Finally, on the morning of the sixth day from the time of commencing treatment, all tetanic spasms had ceased, having only slight rigidity of the muscles, and I flattered myself that there would be no more trouble with this case. I ordered the bromide continued as before, in ten-grain doses every two hours.

Soon after my morning visit I left town and was absent all day, but on my return found my patient dying in tetanic spasms. On inquiry I learned that he had had no bromide of potash during my absence, and he died simply, as I believe, from the nurse neglecting to give the bromide of potash as directed. He was without the medicine eight hours.

**CASE 3.** L. B., aged seventeen years; general physical condition delicate. He was a native of Germany, but of Jewish birth, and could speak but a few words of English. Four or five days previous to my first visit he had accidentally pierced his hand with a paper file just external to the metacarpal bone of the little finger. He presented well-marked trismus at intervals, which gradually progressed until opisthotonus was fully developed. He was naturally very obstinate, and not being able to speak or understand English, it was with the greatest difficulty that medicines could be given him. The tetanic spasms were controlled at intervals with chloroform and the bromide of potash given in twenty and thirty grain doses every two hours. For several days

he took the bromide without much opposition, and the tetanic symptoms became less severe. On account of his extreme repugnance to chloroform and determination to take no more, hydrate of chloral was given as a substitute every three or four hours. Sometimes it was given by the mouth, and at others *per rectum*, as the caprices of the patient would allow. When he took the bromide regularly and without opposition, the chloral was needed only to produce sleep.

For nearly four weeks this patient was kept under the influence of bromide of potash, and I would say during those four weeks he averaged twenty grains every two hours. This amount was found necessary to control the tetanic spasms.

Sometimes, when his opposition to taking the potash was very great, it was necessary to forcibly hold him and give him a dose of chloral *per rectum* and wait until he was under its influence before he would take the bromide.

During the first and second weeks chloral was given, sometimes as often as four or five times in the twenty-four hours, to quiet excitement and produce sleep. Throughout all this time he was systematically nourished on liquid food. When all symptoms of tetanus had passed away it was found that he had no mind, and he was sent to the asylum a hopeless imbecile.

CASE 4. White, aged eight years, stout and healthy. He received a badly lacerated and contused wound of the hand by having it caught in a forty-knife cutting box. Four days after the injury, on account of the gangrenous condition of the index finger, I removed it at its middle joint, leaving the end of the bone to be covered over by granulations, as it was thought best not to cut off the protruding bone. After this the wound progressed quite favorably until the twelfth day after injury, when my little patient presented himself at my office to have his hand dressed as usual. The granulations had by this time covered the end of the bone and were quite luxuriant. In directing a warm spray of carbolic-acid solution on the gran-

ulating surface for the purpose of cleansing, I noticed a peculiar expression of countenance and a sudden contraction of the flexor tendons of the arm. He complained of slight pain at site of wound, and a stiffness of muscles of jaw, together with a contracted feeling in throat and chest. This lasted for a moment, accompanied with a look of contentment or mild form of sardonic laugh. I thought I recognized the trouble as being trismus, and on examining his pulse found it quite frequent. He was sent home, put to bed, and five-grain doses of bromide of potash ordered every two hours. At my evening visit I found him with his jaws stiff; at intervals of a few minutes they were locked tight, and there was general rigidity of the muscles of abdomen and back.

I advised immediate amputation of the finger at its metacarpo-phalangeal joint. His parents objected, but finally consented in a few hours, as the spasms were progressive. On the following day the spasms were less severe and of not so frequent occurrence, the bromide of potash being given at intervals of two hours.

By the afternoon of the third day after amputation, the spasms had gradually grown more severe and opisthotonos was well marked. The potash was now increased to ten grains every two hours, and chloral hydrate in five-grain doses at intervals varying from three to four hours, according to the degree of excitement, etc.

From this time on he took ten grains of bromide of potash every two hours for three weeks, when it was gradually reduced in dose and given at greater intervals for two weeks more. During all this time chloral was given in five-grain doses, by either mouth or rectum, when the patient was very much excited or when sleep was desired. I would say he had an average of four or five doses of chloral in every twenty-four hours. This boy had beef tea, milk, and soft-boiled eggs at regular intervals during the whole period of sickness. He was discharged well, having made a perfect recovery without any impairment of mind or body, except the loss of the index finger.

To summarize: The first case was treated with bromide of potash and chloroform; recovered. The second case with bromide of potash and chloroform, and, although the mildest of the four cases, died, I think, simply from neglect to keep up the administration of the potash. The third case was treated with chloroform, bromide of potash, and chloral; recovered physically, but mentally is a wreck. Whether the latter was due to the bromide or chloral, or not, I am not prepared to say. The fourth case was treated by amputation, bromide of potash, and chloral, with perfect recovery in every respect.

In all these cases the secretions were carefully looked after, and as I have said, liquid nourishment was administered systematically; when they were not able to take sufficient by the mouth it was given *per rectum*. Perfect quiet was enjoined upon all, and maintained as far as possible in the sick-rooms, as I regard it of vital importance for these cases to be free from any and all exciting influences.

And now, in conclusion, I would say that I have taken the illustrative mode of presenting to your consideration the treatment of acute traumatic tetanus, thinking perhaps it would better serve my purpose than to go into an exhaustive consideration of the many remedies that are used in tetanus to no advantage, and with which I have had no personal experience; besides, I believe in bromide of potash we have a drug which in its physiological action is of all known remedies the one best suited for the treatment of this disease.

If in this imperfect and hurriedly prepared paper I have succeeded in directing the attention of the thoughtful and practical members of this body to this subject, I shall consider that my labor has not been in vain.

LEBANON, KY.

NOTHING will trip the light fantastic toe with more ease than a loose brick in the sidewalk. *Merchant Traveller.*

## LARYNGEAL SYPHILIS.\*

BY A. B. THRASHER, M. A., M. D.

Why this disease should be found manifesting in the larynx, when it is constitutional in character and affects nearly every organ and tissue of the human body, seems to me hardly worthy of discussion; yet, it is true, in not every case of general syphilis is the larynx affected; and why it is attacked in the few cases may never be possible to more than conjecture. The old story of the place of least resistance, *locus minoris resistentiæ*, must perhaps still suffice to cover our ignorance of the real truth.

The percentage of syphilitic cases in which the larynx is affected is not very well determined, as the statistics vary from Lewin's 4.8 per cent to Sommerbrodt's 34 per cent. Of course these variations are because of the uncertain time of the appearance of the laryngeal complication.

It occurs as a secondary, or more frequently as a tertiary manifestation. The secondary manifestations generally accompany similar lesions of pharynx, mouth or skin, while the tertiary or the congenital disease is not infrequently found alone.

*Symptoms.* The symptoms vary in the different stages of the disease and in different persons affected. The secondary lesions, by which we mean the milder forms usually occurring within twelve months after the initial sore, are generally limited to hyperemia, condylomata, superficial ulceration. Mackenzie is of the opinion that mucous tubercles are rarely or never seen in secondary syphilis, while Lennox Browne thinks these warty growths are not infrequent at the points of most irritation, especially where there is much moist secretion. I have seen in one case a well-marked papilloma springing from a condylomatous patch of the ary-epiglottic fold.

The rapid acute hyperemia of secondary syphilis can hardly be mistaken for any thing else, when we take into consideration the other symptoms of mucous membrane and skin. A week's constitutional treatment will always settle the diagnosis.

In the latter stages of syphilis occur the for-

\* Read at the May meeting of the Kentucky State Medical Society, at Richmond, 1889.

mations of gummata, deep ulcerations, and affections of the cartilages. Not infrequently the first symptom of this affection is dysphagia, as the epiglottis is the most frequent seat of the ulceration. This is because of the direct irritation of the ulcerated surface by the passage of the food, and not because of any real difficulty in swallowing, since the entire absence of the epiglottis does not materially influence deglutition. When the cartilaginous framework of the larynx becomes affected deglutition is much more painful.

The voice is affected where there is involvement of the vocal bands, or an interference with the mechanism of their movement. The latter may be accomplished by swelling of the arytenoids, an infiltration of the muscles moving them, or by a pressure on the innervating nerve, as a rule, by enlarged lymphatic glands.

There is cough when the secretions drop into the larynx, and especially when there is involvement of the trachea in the syphilitic process. The character of cough depends on the amount of destruction and the position of the lesion. The severity of the cough is in no way proportionate to the amount of damage by the disease, as great destruction may be accompanied by but little, while a small ulcer may cause considerable cough.

Respiration is not apt to be interfered with; yet, when there is perichondritis with much edema, the obstruction may be so great as to threaten suffocation. Cicatricial contraction from the healing of extensive ulceration may cause a slowly progressive contraction of the breathing orifice until tracheotomy must be resorted to in order to save life.

Pain is not a marked feature of laryngeal syphilis. Indeed, its absence is a prominent point in differential diagnosis when the amount of ulceration is taken into consideration. During, however, phonation or deglutition pain may be present, varying much in severity, but rapidly ceasing when the larynx is brought to rest or the bolus of food ceases to irritate.

Glandular enlargement is general, and the cervical glands anterior and posterior are complicated. This is a point worthy of notice when differentiating from cancer and tubercle. But it is by means of the laryngoscope that

the most characteristic evidence is obtained. We now find that the buccal surface of the epiglottis is first attacked, then the ary-epiglottic folds, vocal bands, and the deep cartilages. There is a variegated appearance to the image, caused by the limited area affected and by the different stages of the disease in the same larynx, or indeed in the same ulcer. Since the ulcer is generally the result of a broken-down gummy tumor, it is deep and presents a characteristic "punched out" appearance. There are one or two large deep ulcers surrounded by a zone of intense hyperemia rather than a number of small ones. Frequently but one side of the larynx is affected, while the unaffected side presents a normal appearance. When the cartilages are attacked there is usually edema of the overlying tissues. The swollen tissues may for a time disguise the underlying disease, and it is in cases of this character that difficulties in diagnosis occur. As we might suspect, from the depth of the ulceration and the rapid tissue destruction, great distortions of the larynx arise. Even when the speaking voice is not much affected the laryngeal image may be entirely changed. After the ulcerations have healed the contractile connective tissue distorts the parts in the most grotesque fashion. Should these deposits of connective tissue be in the interior of the larynx, an increasing cicatricial stenosis may be the result.

*Differential Diagnosis.* In the majority of cases but little difficulty of diagnosis will be experienced; yet there are cases so complex and obscure as to puzzle the most skillful diagnosticians.

The diseases most likely to be confounded with syphilis are tubercle and cancer. In tubercle, and especially cancer, there is more pain than in syphilis, and the pain is more constant. In cancer the pain is lancinating, radiates to the ear, and may be felt at any time without reference to irritation of larynx.

The voice is more changed in cancer and tuberculous disease, although in exceptional cases where the vocal bands or arytenoid cartilages are involved this is not true. The classical pathognomonic syphilitic voice is usually more easily recognized when the acute observer has already detected constitutional syphilis.

Cough is much more pronounced in phthisis than in either of the other conditions, yet, when associated with a chronic bronchitis, the difference may not be marked.

The sputum is not so abundant as in tuberculous laryngitis, or as in the ulcerative stage of carcinoma, and is rarely tinged with blood.

Deglutition is more impeded in tuberculous or cancerous ulceration.

The syphilitic ulcer develops rapidly in a few days, the cancerous requires weeks, and the tuberculous months. Syphilis attacks preferably the upper surface of the epiglottis, tubercle the under surface, cancer the ventricular band. In syphilis there is a solitary serpiginous ulcer with sharp edges surrounded by an areola of hyperemia; in tubercle there are numerous shallow ulcers, or these have run together, forming a large ulcer with ragged, nibbled edges; the cancerous ulcer appears on the summit on an angry tumor and is surrounded by highly inflamed tissue. In tubercle there is, as a rule, anemia of faucial and laryngeal mucosa, while hyperemia is the rule with the other two affections.

Edema is a marked feature in tuberculous laryngitis, while it is either not present or exceedingly transient in syphilis.

Enlargement of cervical glands, anterior and posterior, is indicative of syphilis, and is either not present or not so marked in the other diseases. Age may exclude cancer; for while laryngeal syphilis may show itself at any age, yet most cases occur between twenty and forty. Lupus of larynx might be mistaken for syphilis, yet the disease is so rare as to not fall within the observation of most laryngologists. When the only manifestation of lupus is in the larynx, the administration of antisyphilitic remedies might be required to confirm the diagnosis.

*Treatment.* The constitutional treatment of laryngeal syphilis does not differ from the routine antisyphilitic treatment: Iodide of potash in as large doses as it will be borne, tonics, sedatives, good food and air, just as any case would require.

Locally the application of a twenty five per cent solution of argentum nitras to the ulcerated surface daily, or every second day, will facilitate the healing process. When there is a tendency

to moist granulations, they may be cauterized with solid nitrate of silver fused on a platinum probe, or dry calomel may be blown over them. When there is a tendency to a contraction of the orifice by the adhesion of ulcerated surfaces, a careful separation of the adhering surfaces may keep them apart until the ulcers have healed. In case of sudden edema tracheotomy should at once be resorted to. In case of cicatricial contraction, giving rise to dyspnea, a tracheal tube should be inserted. After tracheotomy attempts may be made to dilate the stricture or to cut the adhesive bands. In the majority of cases of syphilitic laryngeal stenosis the tracheal tube must be worn throughout life.

The effect of congenital syphilis on the larynx is quite like the tertiary manifestations of the acquired form, and should receive like treatment.

CINCINNATI, O.

## REPORT ON PROGRESS IN OTOLOGY.\*

BY J. MORRISON RAY, M. D.

The large space given in many of our leading medical periodicals to the discussion of diseases of the ear, and the increase in the number of text-books and magazines devoted to their study, indicate that a large number of medical men are yearly becoming more familiar with ear diseases, and devoting more time to their diagnosis and treatment. Such evidences of progress lead us to hope that we are nearing the time when we shall meet with fewer cases of irremedial deafness, and that the old practice of letting the ear troubles run their course, with the idea that the children will outgrow them, is rapidly passing into oblivion. Thus that opprobria of our science, chronic deafness, will less often be met with in practice.

A review of the literature of otology for the past year shows that the science has not been enriched by any strikingly original contributions. A discussion, however, of several leading points has been vigorously carried on, and will no doubt lead to much good. The

\*Read at the May meeting of the Kenton County Medical Society, Richmond, 1899.

question of most importance is the prevention of ear diseases, and the hygienic and prophylactic treatment of those predisposed to such troubles. The question of heredity is not considered in many of the most popular textbooks, while others give it only a passing notice. Bezold has observed that out of 49 cases of chronic deafness, where heredity was considered, 29, or over 50 per cent, showed that it played an important rôle. If one will carefully study the etiology and subjective symptoms in cases presenting certain defects of hearing, he will be forced to the conclusion that while deafness *per se* is rarely transmitted from parent to offspring, certain cases indicate strong family tendencies toward deafness. This is especially true of slow-progressing disease, commonly classified as sclerosing catarrh of the middle ear. It develops without pain and resists all treatment. It will be found that the family history in these cases show ancestors who have suffered from a similar affection. During the present year I have been consulted by a family of four adults in whom this form of deafness had become established. Each member of this family first gave evidence of the defect in hearing on reaching adult age, and on examination they presented the same pathological changes in the ear. The father of this family was known to have suffered from the same condition. Similar observations to this have convinced me that this especial form of chronic catarrhal disease, while not present during early life, will frequently show itself in adults in the family of parents suffering from such a disease. If heredity plays such an important rôle in predisposing to ear diseases, hygienic measures and preventive treatment are of prime importance. In a discussion before the American Otological Society, Drs. Agnew and Roosa set forth in strong terms the importance of attention to the hygiene of patients affected with or predisposed to ear disease, Dr. Agnew said: "It is important that the whole question of regime should be considered. The habits of living, the diet, the dress, exercise, bathing, and the use of friction should be regulated. The patients should be taken from badly-drained houses and low lands and put in a better sanitary location." A

change of climate is often of much importance. A lady consulted me, suffering from a most obstinate tinnitus. She had been troubled at intervals for several years. It was generally ushered in by a slight attack of nasopharyngeal catarrh. It had subsequently yielded to treatment under a well-known New York aurist. I had no trouble in one or two attacks of relieving the distress, but finally all treatment seemed to fail, and I advised a change of climate. In a short time, without treatment, it yielded to the climate of Florida.

The conditions most often considered as predisposing to ear disease are alterations in the nose and naso-pharynx. The throat, nose, and ear are so closely associated anatomically, physiologically, and pathologically that it seems useless to state the fact. Nevertheless many still treat diseases of the ear without giving the nose and throat serious consideration. All cases of chronic catarrhal disease in the ear are accompanied by nasal or naso-pharyngeal disturbance. These consist of some form of obstruction to nasal breathing, as hypertrophies of the middle and inferior turbinated tissue, deviations of the nasal septum, and thickening or vegetations in the naso-pharynx. The respiratory function of the nose is essential for perfect hearing, since in this manner the air pressure in the middle ear is maintained. The treatment of these obstructions to nose-breathing becomes a necessity when we expect to cope successfully with the ear disease. This treatment is now considered to be essentially surgical. For the turbinated hypertrophies most rapid relief is gained by the free and judicious use of the galvano-cautery. For the deviated septum the nasal septum the saw becomes a necessary instrument. For hypertrophies in the naso-pharynx the post-nasal cutting forceps can be handled to the best advantage and to the most rapid relief of your patient. From their situation it would seem almost impossible for the tonsils to obstruct the eustachian tubes, but by pressure indirectly they do often produce this effect. This, combined with their tendency to cause mouth-breathing, so prejudicially affects the ear as to require abscission in many cases.

*Differential Diagnosis of Ear Diseases.* A question of much importance, and one that has recently occupied the attention of the most prominent specialists in this country and Europe, is the differential diagnosis between diseases of the middle ear and diseases of the internal ear or acoustic nerve. On this point often depends a correct prognosis and the proper treatment. Diseases of the middle ear, as a rule, are improved by remedies applied directly to the ear and to the naso-pharynx, while such interference tends to exaggerate the deafness when it depends on disease of the nervous portion of the ear. It has long been known that while inspection of the drumhead is of much value, it gives no evidence of the amount of loss of hearing, nor always of the seat of the trouble. Therefore other means than inspection of the drumhead are found to be necessary for a proper location of the disease. To meet this requirement the experiments of Weber and Rinne with tuning-forks were brought into requisition. Within the present year several interesting papers emphasizing the usefulness of the tuning fork have appeared in the Archives of Otolaryngology. The value of this test depends on the ability of the patient to decide whether he hears the vibrating fork when it is held in contact with the bones of the head or when the sound reaches the ear through the air. Dr. Roosa has studied the subject in an enthusiastic manner, and from personal observation of his clinical work I am convinced of the correctness of his statements. Dr. Roosa makes the following deductions:

1. If one ear be normal as to hearing power and the other abnormal, and a vibrating tuning-fork (C<sup>2</sup>) be placed upon the vertex or the teeth, if its sound be intensified in the ear whose hearing power is diminished, there is disease of the external or middle ear, but no lesion in the labyrinth or nerve.

2. If, under the same conditions as above, the tuning-fork be heard not better in the worse ear, even if the meatus be stopped by the finger, there is disease of the labyrinth, acoustic nerve or brain.

Dr. J. B. Emerson undertook a series of observations upon healthy and diseased ears with

reference to their power of hearing a tuning-fork. And from a study of his observations Dr. Roosa says the following is true: "If the tuning fork (C<sup>2</sup>) be heard louder and longer through the air when placed near the ear than it is when placed on the mastoid process, we probably have a disease of the nerve; while, if it be heard better through the bone, we have disease of the middle or external ear." For the sake of brevity we may say, if, in a case of impaired hearing, aerial conduction be better and longer than bone, we have disease of the internal ear; if bone conduction be better than aerial, there is disease of the middle or external ear. Articles have recently appeared that would seem to modify the tuning-fork test. Yet, if not only the loudness with which the fork is heard but also the length of time be taken into consideration, these statements of Dr. Roosa will be found to be correct. In practice I have found that by bearing this in mind, the use of the (C<sup>2</sup>) fork and a careful study of the history of the case, I am able to differentiate between diseases confined to the middle ear and those affecting the nerve, thereby, when the latter diagnosis is made, saving the patient much useless treatment.

*Complications of Suppurative Inflammation of the Middle Ear.* Physicians who have seen many cases of ear disease are aware that deaths traceable to a suppurative process going on in this organ are not of unfrequent occurrence.

The case of the Crown Prince and Emperor of Germany drew the attention of the entire laryngological world to the subject of malignant disease of the larynx, and thus caused to be written many interesting and valuable statistical papers bearing on the subject. So has the death of Mr. Conkling from complicated suppuration of the middle ear brought forth valuable observations on the subject. From the anatomical situation of the ear, pus accumulations in the tympanic cavity may readily find exit into the mastoid cells, and from thence into the cranial cavity, or they may open directly through the tympanic roof into the middle fossa of the skull. The mastoid cells and their periosteal covering are the parts most frequently involved. This complication

seems to occur more frequently in certain parts of the country and in the practice of certain observers.

Allport, of Minneapolis, says such cases are of frequent occurrence in his practice. Sexton, of New York, has met with very few cases in which he has been compelled to open the cells. In this climate the frequency of the occurrence of these troubles depends much upon the season of the year. Within the last few months, in the city of Louisville, I have met with two cases of true cell disease requiring operative interference, and many in which the periosteal covering of the mastoid process required incision. I attribute this occurrence to an extensive prevalence of nasal and nasopharyngeal catarrhs, exciting suppuration of the middle ear. Dr. Roosa found in 68,555 cases of ear disease that the mastoid was involved in 464 cases, or less than 1 per cent.

The less frequent yet more serious cases are those in which the cranial cavity is invaded. Sexton found in 131 cases, in which complications occurred during suppuration in the middle ear, that 11 proved fatal from cerebral complications. Roosa found, out of 92 cases that 10 deaths occurred. Barr states that in London, in one year, eighty six deaths were due to cerebral abscess from ear disease, and that in the eight largest towns of Scotland, during the same time, there were twenty-six deaths from the same cause. Meyer and Ogle found, out of 101 cases of cerebral abscess, 29 to be due to ear disease. The impetus given the subject of cerebral surgery by the studies and work of Mr. Victor Horsley has led to most satisfactory results in its application to abscess depending upon ear disease. Dr. Macewen, of Glasgow, has opened the skull seven times for abscess due to ear disease, and has succeeded in saving five lives. Successful cases have been reported by Barker, Caird, Victor Horsley, Greenfield, and others. The question of the location of the abscess is of first importance. From a study of 76 cases, Barr found the temporo-sphenoidal lobe involved in 55, the cerebellum in 13, both temporo-sphenoidal and cerebellum in 2, other portions of the brain in 4. The symptoms demanding interference are, lessening in flow of the pus from the ear,

increase in the disagreeable odor, increased or sometimes diminished temperature, slow pulse, rigors, coma or paralysis, and often optic neuritis. The parts involved being near the exit of many of the cranial nerves, paralysis of one or more is often observed, but the recent researches into localization have not aided much in placing abscesses from ear diseases. Before opening the skull secure, if possible, free drainage from the middle ear. If the symptoms do not disappear, then open the mastoid cells. If there is still no abatement of the symptoms, open the cranial cavity and search for the abscess, since in a large portion of the cases the abscess is in the temporo-sphenoidal lobes, which lie in contact with the roof of the tympanic cavity. Macewen operates by trephining the squamous portion of the temporal bone an inch and a half above and half an inch below the external auditory meatus, and then searches for the abscess by means of a hollow needle. This operation offers a chance for success in a class of cases heretofore considered hopeless. Therefore we should, without delay, adopt the operative measure that in certain hands has proven so brilliantly successful.

*Therapeutics.* Cumberbatch reports the results gained from electrolysis in obstruction of the eustachian tubes. His method is by the use of an electrode, fitted into an eustachian catheter and placed in position. The electrode is then pushed into the tube, and the connection to the battery made with the negative pole. A sponge attached to the positive pole is placed on the back of the neck. The results obtained in cases where the tube was firmly obstructed were sufficiently encouraging to call for further use of the method. The use of injections and dilators in the eustachian tube and middle ear have not proven of great advantage, and many have come to the conclusion that such treatment offers no prospect of benefit, and therefore does not warrant the risk that their use involves. The researches of Netter on the bacteriological nature of ear diseases show that the microbe reaches the ear through the eustachian tube from the throat. Therefore he advises in all cases of suppuration of the middle ear that not only should

antiseptics be used in the ear, but the nose and pharynx should be treated by similar means. The new antiseptics that are constantly being introduced have nearly all been tried in suppuration about the ear. Of these creolin has been used most extensively. Rheinhard and Ludwig, from a trial, consider it no better than agents already in vogue. I have given it a trial in one and two-per cent solution, but can find no reason for continuing it to the exclusion of other more popular drugs. The most valuable of all agents for cleansing the ear is peroxide of hydrogen. Since cleanliness is the prerequisite to the treatment of pus formations in the ear, this agent becomes invaluable. In a paper commending its value, read before the Louisville Medico-Chirurgical Society, I drew the following conclusions from its use in ear diseases:

1. Owing to the strong power possessed by the peroxide of hydrogen as a pus-destroying agent, it is invaluable in the treatment of purulent accumulations, especially when situated in cavities where ordinary methods for their removal are insufficient.

2. In acute purulent inflammation of the middle ear it will, unassisted, cut short the discharge in from three to ten days.

3. In chronic suppuration of the middle ear uncomplicated by necrosis, as a preliminary cleaning agent to the boric-acid treatment, it aids materially the therapeutic powers of this method.

4. It hastens rapidly the healing of abscesses connected with or due to necrosed bone, as shown by its use in mastoid disease.

Politzer, in 1880, recommended pilocarpine in recent cases of labyrinthine disease, on the theory that it stimulated the secretions, and thus hastened the absorption of the exudate. Kostegarten, on the same principle, tried it in old-standing diseases of the middle ear. He says it causes an exudation, and from this ensues pliability of the sclerosed tissues, moistening and softening adhesions, and thus the conducting apparatus becomes more movable and capable of transmitting sound vibrations.

While great advancements have been made in the therapeutics of chronic suppuration of the middle ear, there remains a certain num-

ber of these cases that resist all medicinal application. Dr. Sexton, of New York, now recommends for these cases surgical methods of treatment. In general surgery it is familiar to all that chronic suppuration is always due to obstructed drainage or to disease of the deep tissues, usually bone. So, in chronic ear discharges there is obstruction to a free outflow of the pus, due to a circumscribed necrosis of the fundus of the ear. The rational treatment here is to give exit to the pus, and cleanse the cavity with antiseptic solutions.

LOUISVILLE.

## Societies.

### THE KENTUCKY STATE MEDICAL SOCIETY.

Proceedings of the Thirty-fourth Annual Meeting, held at Richmond, Ky., May 8th, 9th, and 10th, Dr. L. S. McMurtry, of Danville, President, in the chair.

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#### SECOND DAY—THURSDAY, MAY 9TH. MORNING SESSION.

Dr. J. M. Mathews, of Louisville, read a paper on the Importance of Rectal Examinations to Life Insurance Companies.\* This paper was not discussed.

The *Report on Ophthalmology* was read by Dr. S. G. Dabney, of Louisville. (See p. 353.)

#### DISCUSSION.

Dr. J. M. Ray, of Louisville, said he had listened with interest to the report. As the reader had truly said, the operation for cataract was one that interested every one engaged in the practice of eye diseases. I remember very well how cataract patients were treated in hospitals some years ago. They were taken into the hospital several days before the day set for operation, so as to be under preparatory treatment. After operating they were placed in bed and left quiet for days. Things have changed in recent years. I have, after operating, five times since January 1st, simply placed a light bandage over the eye, allowing patient

\*The full text of this paper will be reproduced in a special issue of the American Practitioner and News.

to sit up in an easy chair, and have had no bad symptoms, not even severe iritis. I would like to call attention to the fact that we now operate much earlier in cataract than formerly. At one time, when a case of cataract presented itself for treatment, the patient was told that nothing could be done until he became too blind to see objects. Now, principally through the advocacy of a few English ophthalmologists, the operation is done much earlier.

At the last meeting of the British Medical Association this subject was discussed, and all agreed that with proper precautions there was no more danger in removing a lens partially opaque than one mature. In operating I always proceed as follows: I wash the parts about the eye with soap and water, and then flood the eyelids, conjunctiva, and cul-de-sac with a warm solution of boric acid. I have cocaine made up in a saturated solution of boric acid. After removing the lens I again flood the eye with the boric solution. I formerly used bichloride of mercury solution, but my friend, Dr. Webster, told me that he believed, and that it had also been observed by British surgeons, that the bichloride solution produced opacity of the cornea. I have seen it irritate the conjunctiva very much. An interesting question referred to in the paper is the subject of weak cylinders. I remember to have heard Dr. Chisolm's paper read at Cincinnati, and was surprised at the large number of cases in which he prescribed such lenses. I believe we all prescribe more weak cylinders now than formerly, yet so weak a glass as  $\frac{1}{4}$  dioptric is rarely ordered. If mydriatics were always used in such cases, I believe the amount of astigmatism would be found greater. The teaching of Stevens in reference to insufficiency and multiple tenotomy have not been fully confirmed by other observers. In this most remarkable book numbers of cases of different kinds of nervous symptoms are wonderfully relieved by his operative procedure. Dr. Webster reported forty cases in which he followed the teachings of Stevens. While he is inclined to give the operation serious consid-

eration, he has not been able to obtain such results as are described in Dr. Stevens' book.

Dr. R. C. McChord, of Lebanon, read a paper on Traumatic Tetanus. (See p. 356.)

Dr. John Young Brown, of Henderson, read a paper on Impermeable Urethral Stricture.\* (No discussion.)

Dr. E. S. McKee, of Cincinnati, read a paper on Ovarian Prolapse.\* (No discussion.)

Dr. J. B. Evans, of Riley Station, reported a case of extra-uterine pregnancy, with exhibition of fetal bones, etc., as follows:

August 6, 1885, I saw a colored woman, twenty-three years of age; she was in good health, married, and the mother of one child eighteen months of age. Examination revealed a tumor in the left side. It was round, hard, and bulging, and appeared to be in size six by eight inches. Menstruation had stopped about four months before this visit, and the patient thought she was again pregnant. Her sensations, however, were not as they were in the former pregnancy; she was very restless and had a slight show of blood at times; beyond the stoppage of the menses there was no symptom of pregnancy. The womb was found to be normal. She suffered some abdominal pain, and complained of constipation. I prescribed for the constipation, and left. August 8th I again saw the patient. The purgatives had acted well, excluding fecal accumulation. The tumor was as before. I could not detect motion or fetal heart sounds. I did not make a clear diagnosis. I thought the tumor might be ovarian, and recommended an operation for removal. This was declined. Patient removed to an adjoining county, and passed from under my care until April, 1886, when I again saw her. At this time the tumor was larger than when I first saw it, and the patient reduced in flesh. She was also low spirited, had loss of appetite, and suffered with pains in the bowels. I still recommended an operation. In October, 1886, peritonitis set up, from which

\* These papers will appear later in the American Practitioner and News.

she suffered greatly. This became chronic. The patient was very much reduced; she was given opium to relieve pain, salts to regulate the bowels, and supporting treatment for a year. In July, 1887, she began to have watery discharges from the bowels, composed of fecal matter, broken-down tissue, etc. The patient was very low and suffering a great deal. The abdomen was much swollen. The patient was delirious at times with pain. In October, 1887, she began to pass some fetal bones, one or two at a time; it then would be days and sometimes weeks before any more would pass. The long bones were the first to pass. In June, 1888, I removed the head bones from the rectum; they, being large and flat, would not pass the sphincter without assistance. About the time of the first passage of bones from the bowels the peritonitis began to subside, and the patient gradually grew better. She is now a stout, healthy woman. She has not since become pregnant.

To sum up: Patient first seen August 6, 1885; tumor of left side, menses stopped, health good. April, 1886, found tumor somewhat larger than at first; health of patient about same. October, 1886, peritonitis had supervened; patient *in extremis*. July, 1887, watery discharge from bowels; great suffering. October, 1887, passed fetal bones; began to improve. June, 1888, last of bones passed; tumor gone; woman well. Has had nearly three years of suffering.

Dr. Archibald Dixon, of Henderson, read a paper with the report of a case of tubal pregnancy, delivered at term.\*

#### DISCUSSION OF THE PAPERS OF DRs. EVANS AND DIXON.

Dr. Cecil said he had listened with more than usual pleasure to the valuable reports just read; each of the cases presented features of a subject always of great importance and unusual interest. Dr. Dixon's report of a case of tubal pregnancy going to full time without rupture presented a condition of such infrequent occurrence that, in the absence of an unusually careful dis-

section, and to this added a microscopic examination of the walls of the sac, he was disposed to question the correctness of the diagnosis; in fact, considering the anatomical structures involved, he doubted if it were possible for tubal pregnancy to go to full term without rupture. Notwithstanding the fact that such cases are recorded, in the light of modern investigation it is generally agreed that rupture will occur by the end of the fourth month.

Referring to the case reported by Dr. Mann, in which the fetus had remained unchanged for a long period (about three years), he mentioned the case reported by Playfair, in which the fetus was retained unchanged in the abdominal cavity for fifty-two years—the specimen now to be seen in the museum of the College of Surgeons. He thought the case of Dr. Evans, and the specimens exhibited, of exceeding great interest, and stated that ulceration into the rectum and discharge of the fetal remains through the fistulous opening occasionally happened, several instances of which are to be found so recorded.

He believed that the vast majority of cases of ectopic gestation were originally tubal in variety, and that no doubt many cases reported as of the abdominal variety had been in the beginning tubular, but that rupture had taken place and the patient had survived the rupture. He did not agree with Mr. Tait, and others of the same opinion, that abdominal pregnancy was an impossibility. Too many observers who were the equals of Mr. Tait as pathologists and diagnosticians, and whose opportunities of observation in this particular class of cases were as good as his, had recorded cases which could be explained upon no other hypothesis. The case of Kellar, referred to by Spiegelburg, in which the body and a large part of the neck of the uterus had been amputated, was a noteworthy instance. Mr. Tait had failed to explain this case of abdominal pregnancy, as well as several others reported by men of equally good repute.

Dr. Cecil agreed that it would be hard to

\*Will appear in an early issue of this journal.

conceive of the impregnated ovum finding lodgment and becoming attached to a healthy peritoneum, but thought that we might find explanation for such cases in some of the causes of ectopic pregnancy. Would not inflammation or chronic congestion of the pelvic peritoneum so alter the normal surface as to allow implantation and development of the ovum? He, at least, considered this as good an hypothesis as that the tube should rupture and the rent heal so thoroughly as not to be discoverable. He did not believe that the fecundated ovum would be digested by the normal peritoneal fluid. As to the treatment, he was in full accord with all those who agreed that laparotomy was the best procedure.

Professor Frank C. Wilson, of the Louisville Hospital College of Medicine, read a paper upon the Recent Advances in the Diagnosis and Treatment of Pulmonary Tuberculosis. He referred to the great fatality of this dread destroyer, and the importance of an early diagnosis of the disease if already developed, and, if possible, the discovery of that condition of the system which precedes the actual deposit of tubercle. He then described the pneumatic siren of Dr. Edgar Holden, of Newark, N. J., which consists of a glass cylinder eight or ten inches long, provided with a perforated disk attached to a light spring, which is carried by the air respired to a distance along a graduated scale proportionate to the force of the current. This could be used also in inspiration by reversing it. Tuberculous cases showed a marked diminution of the force of both inspiration and expiration.

The spirometer of Hutchinson would be useful in the same way, measuring the vital capacity of the lungs, which in tuberculous cases is always greatly decreased. He also exhibited the respiratory anemometer of Dr. Holden, an instrument consisting of a chamber in which is placed a light valve, so arranged that it is moved forward and backward by the current of air expired and inspired through the breathing-tube. The valve is connected by cog-wheel and lever with a marking pen, which traces a corres-

ponding curve upon a slip of paper moved along at a uniform rate by clock-work. The curve thus records not only the relative force of inspiration and expiration, but its rhythm and frequency. He referred to the necessity of frequent microscopic examination of the sputa in search of the bacillus of Koch, which might thus be detected soon after being first implanted in the mucus of the respiratory passages.

Under the head of treatment he referred to the use of the apparatus of Waldenburg and its various modifications for the purpose of expanding and developing the lungs by the use of compressed air. Various attempts had been made to combine the use of compressed air in inspiration and expiring into rarefied air, but the apparatus proposed had generally been expensive and cumbersome. This object he had attained in an apparatus which he had had constructed by Tafel Bros. a year ago, and had since been using in his office with much benefit in a number of cases. It consists of two cylinders, one for compressed air and the other for rarefied air, each connected by a tube with a three-way stop-cock, also connected with a breathing-tube, so arranged that by turning a lever the patient may inspire from the compressed air cylinder and then expire either into the atmosphere or into the rarefied cylinder.

The same effect he had succeeded in accomplishing in a much less expensive way by an instrument which he had devised for home use, and might be termed a differential respiratory bellows. He exhibited the instrument and illustrated the manner of using it. The apparatus consisted simply of a bellows divided by a partition into two chambers, the valves so arranged that one side would compress the air and the other rarefy it, each being connected by a branched tube with the common breathing-pipe. With an instrument of this sort the chest could be greatly developed, the expansion enlarged, and the vital capacity markedly increased. The air thus forced into the lungs could be easily medicated by a glass globe holding a sponge saturated with a volatile agent, such as eucalyptol, guaiacol,

carbolic acid, etc., and the vapor thus breathed under compression would reach to a much greater depth in the air-passages than when respired under the ordinary atmospheric pressure.

There was also exhibited the vaporizing apparatus of Charles Marchand for the administration by inhalation of peroxide of hydrogen or of glycezone.

The vaporizer or large geyser, as made by A. G. Armstrong, of New York, was also shown and commended as very efficient and possessing the advantage of allowing the vapor to be taken in under a certain degree of compression.

The importance of properly caring for the sputa from a tuberculous patient and thoroughly disinfecting or destroying every vestige was emphasized, and the danger of transmission of the disease from patient to nurse was vividly portrayed. He also referred to the possibility of communication of the disease from the lower animals to man.

#### THURSDAY, MAY 9TH — AFTERNOON SESSION.

Called to order at 2:30.

On motion of Dr. J. N. McCormack, Dr. C. J. Walton, one of the founders of the Society, was invited to a seat on the platform.

Dr. A. W. Johnston offered the following resolution:

*Resolved*, That section 2, article 4, of the Constitution of the Kentucky State Medical Society shall be so amended as to read, that the second evening of each annual meeting be set apart for the election of officers, by ballot, with closed doors, receiving nominations from the floor, after the calling of the roll by the secretary of the members in good standing whose dues have been paid.

Tabled.

Dr. Ap Morgan Vance made a *Report on the Art of Asepsis*, exhibiting to the Society a "surgical case" of his own construction.

*Antiseptic Gauze.* In the preparation of this gauze you should buy the ordinary excelsior butter-cloth, which the manufacturers

make very hygroscopic. This cloth is placed in a bichloride of mercury solution ranging from 1-1000 to 1-500, and allowed to remain for at least twenty-four hours.

After it has been perfectly saturated run it through the ordinary clothes-wringer into a receptacle, where it is ready for future use.

In preparing iodoform gauze use this as a basis, dusting iodoform over a piece of the size needed in the operation, and the gauze is ready for use.

The receptacle in which this gauze is kept should be an ordinary candy jar, with rubber around the top, so that it may be hermetically sealed.

*Irrigators.* In making irrigators you may use the ordinary denijohn, breaking a small piece from the bottle, and then, by means of a rat-tail file immersed in turpentine, you can file or saw an opening sufficiently large to pass the ordinary sized rubber tube.

In introducing the tube pass the rubber through the neck of the bottle, and, catching it from the outside through the small opening you have made, you are enabled to draw it through, thus constructing one of the cheapest and best irrigators in the market.

*Sponges.* The sponges, being full of sand and other mineral matters when purchased, should be first soaked in clear water, dried, and beaten thoroughly; this repeated several times, the water brings many of the small particles to the surface. All the sand having been beaten out that is possible to be removed, they should be immersed in the first bath and allowed to remain for twenty-four hours. The bath should be of the following proportions:

1. Ac. muriatic ..... 3 ss;  
Aq. dest. .... gal. ss.

They should be then wrung dry and immersed in each bath (wrung dry after each), as follows:

2. Potass. permang ..... 3 ss;  
Aq. dest. .... gal. ss.  
M. ft. sol.

3. Ac. oxalic ..... 3 ss;  
Aq. dest. .... gal. ss.  
M. ft. sol.

- |                             |             |
|-----------------------------|-------------|
| 4. Sod. hypo. sulphite..... | } āā 3 ss ; |
| Ac. muriatic.....           |             |
| Aq. dest.....               |             |
| M. ft. sol.                 |             |

Having been run through several waters, and dried, they should then be immersed in a carbolized solution (1 to 20) until ready to be used.

The dark spots which are seen in many of the sponges, especially the "Potter's sponge," are natural and can not be removed. It may be found necessary to run the sponges through the baths more than once; but this, however, should not be done too often, as the action of the strong acids is deleterious to the integrity of the sponges.

*The Surgical Case.* The case consists of a hard wood bottom containing four blocks in which are inserted the instruments, each block having over it a hard rubber immersion pan. Above this hard wood tray is a leather compartment fastened to the tray by side clasps, the leather part forming the top proper of the case. In the top, which opens as an English grip-sack to each side, may be found restoratives, anesthetics, antiseptics, as arom. spiritus ammon., digitalis, whisky, chloroform, ether, cocaine (in solution), bichlor. mercury tablets, hypodermic tablets (of morphia and atropia), carbolic acid, sweet oil, cologne, amyl nit., and colloidion, these arranged in rubber-protected bottles in rows along the sides of the tray. Again, there may be found in the case a battery, hypodermic syringe and aspirator, Esmarch bandage, bone mallet, razor, strap, and brush, rubber drainage-tubes, rubber irrigator, nail-brush, irrigator tip, rubber tourniquet, bichlor. gauze and bandages, adhesive plaster, retractors, iodoform, boracic acid, rubber and silk ligatures, medicine glass; and in the instrument case may be found any instrument which would be necessary in any surgical operation of any magnitude.

A paper on Syphilitic Ulceration of the Upper Air-passages was read by M. F. Coomes, M. D., Louisville.\*

Laryngeal Syphilis was the subject of a

paper by A. B. Thrasher, M. D., Cincinnati. (See page 359.)

#### DISCUSSION.

Dr. S. G. Dabney said: I was greatly interested in the papers of Dr. Coomes and Dr. Thrasher. Syphilis of the upper air-passages is of interest both as to diagnosis and treatment. There are unquestionably some lesions which may be pronounced certainly syphilitic—such as certain perforations of the palate and forms of ulceration. But there are also cases wherein the diagnosis is both a very difficult and a very delicate matter. During the past year I have seen several such. One case was that of a young lady of irreproachable character. When I was called in I found the septum of the nose bulging so as to touch the ala on either side; it was clearly a case of abscess of the septum, though the attending physician had been treating it for erysipelas—a course that was perfectly natural, as the lids, forehead, nose, and cheeks presented an appearance precisely like that of erysipelas. The abscess was opened, and the case progressed well, except for a slight sinking in of the nose. I did not think then, nor do I believe now, that such a lesion was sufficient to warrant constitutional treatment. Had such a course been taken, the diagnosis would always have been uncertain. There was absolutely no history of any other lesion, except that a month or two previously there had been a sore on the cheek near the angle of the mouth; some four or five months later a distinctly syphilitic eruption appeared, a rupia most marked about the wrist. This was seen by Dr. Ap Morgan Vance, and the patient has since been under general treatment. Such affections of the septum are great rarities. In Wagner's book on the Nose a similar case, due to syphilis, is reported (quoted from Dr. Samuel Johnson, of Baltimore), and two other cases, non-syphilitic. Morell Mackenzie says he has seen but one such case. Another case, where diagnosis from the local lesion was impossible, presents itself to my mind: A young married lady of the highest social standing and character was referred

\*Will appear in full in a coming issue.

to me by a prominent physician of Louisville. I found on the anterior pillar of the fauces of either side an ulcer somewhat crescentic in shape and of distinctly syphilitic appearance; the symmetry was perfect—"the Dutch garden symmetry," as a recent author describes it. Not the slightest suspicious history could be obtained. When I called to see the family physician, he at once remarked on the very suspicious nature of the case. The ulcers healed readily under local applications, and now, after about six months, not the least evidence of further trouble has been seen, though the patient has been closely watched by her physician, a most excellent one. In cases like these I think it best to use local measures only until unmistakable evidences of syphilis have appeared; otherwise we obscure our diagnosis, and will probably never be quite sure as to whether our patient is syphilitic or not.

Dr. W. H. Wathen, of Louisville, read the *Report upon Gynecology*. He confined himself to pelvic hematocoele. He referred to the generally accepted definition of pelvic hematocoele, a blood tumor in the pelvis, encapsulated, within or without the peritoneal cavity. He said that all pelvic hematocoeles were extra-peritoneal, and that it is not possible for hemorrhage in the peritoneal cavity to become rapidly encysted so as to form a fixed tumor in the pelvic or the abdominal cavity; that the blood is mixed with lymph, and coagulates so slowly that it is not confined in any one place in the cavity, but changes its position upon the movements of the body, obeying the laws of gravitation; that the blood could not be confined by a layer of effused lymph immediately above it, and that if the hemorrhage into the cavity is at all considerable, death would probably result before it could be confined by adhesions of the superimposed intestines. Intra-peritoneal hemorrhage is nearly always fatal. Mr. Tait has seen nearly one hundred cases, and they all died, except two, upon whom he did abdominal section. He referred to the fact that the blood never becomes encysted in intra-peri-

toneal hemorrhage from defective ligation in laparotomy for the removal of tubes, ovaries, etc. He gave, as causes of encapsulated hematocoele, sudden metrorrhaxis of normal menstruation, or of pseudo-menstruation following abdominal or pelvic operations, and rupture of a tubal pregnancy. He said that intra-peritoneal hemorrhage is nearly always caused by primary or secondary rupture of an ectopic gestation. The tumor may extend out of the pelvis, and even as high up as the umbilicus in extra-peritoneal hematocoele, as the peritoneum is a tough and an elastic membrane, and so easily separated from its attachments that hemorrhage in the loose pelvic connective tissue may dissect up the tissues under the peritoneum between the broad ligaments, between the rectum and vagina, from around the rectum, from the sides of the pelvis, and from the anterior abdominal wall. In hemorrhage into the cavity of the peritoneum no well defined tumor or fixation of the uterus can be felt in a bimanual examination, while in pelvic hematocoele the symptoms are nearly pathognomonic. He gave the symptoms and diagnosis of hematocoele, and advised against surgical interference unless the sac ruptures into the peritoneum or supuration is manifest. If the fluctuation can be detected from below, he recommended making an opening and giving free drainage to the vaginal vault; but, if fluctuation is well-marked above the pelvis or ruptures occur into the peritoneum, abdominal section should be done.

Dr. A. W. Johnston, in opening the discussion of Dr. Wathen's paper, stated that the battery should never be used if rupture had occurred. The case should either be left to nature or a laparotomy should be done. The chief difficulty in diagnosing hematocoele is in differentiating those confined within the wall of the peritoneum from those without the peritoneal covering.

Dr. Wathen, in closing the discussion, said that the chief point he wished to impress upon the Society was, that there is no such thing as an intra-peritoneal hematocoele. If the blood should drain into the

peritoneum, the result, a tubal pregnancy or a rupture should occur in any of the blood-vessels of the abdomen, it is a hemorrhage not encysted, and it is necessary we should have an effusion of lymph before this can be confined, consequently you can not have a fluxation of an intra-peritoneal hematocele unless it be secondary. Strictly speaking, there is no such thing as an intra-peritoneal hematocele. The only hope of saving the woman's life is a laparotomy; ligate the tubes and remove them. Primary abdominal pregnancy is an impossibility, while secondary is a very unusual thing.

Dr. J. N. McCormack offered the following resolutions:

WHEREAS, The law regulating the sale and compounding of drugs requires that towns of one thousand inhabitants and over shall have a graduated pharmacist, and, as the lives of the people and reputation of physicians are endangered by incompetent and unscrupulous men engaged in the sale of drugs; therefore,

*Be it resolved*, That this Society co-operate with the State Pharmaceutical Society in having the laws amended so as to require every man engaged in the State in the compounding of drugs to be a graduate of pharmacy.

*Be it resolved*, That the president appoint a committee of three to confer with the State Pharmaceutical Society, which meets Wednesday, May 15th, at Crab Orchard Springs.

*Be it resolved*, That the secretary of the State Board of Health and the secretary of the State Medical Society be appointed members of this committee.

Carried.

Committee: Dr. McCormack, Dr. Steele Bailey, Dr. J. G. Carpenter.

[TO BE CONCLUDED.]

## Correspondence.

### PARIS LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

The *Journal de la Santé* has published an interesting note on the aviary origin of diphtheria. Different memoirs have been published which have already shown that domestic birds of a poultry-yard may transmit diphtheria to man. The following very curious and very interesting example is given by Dr. H. Petit: Dr. Bild, who has been in practice for the last thirty years in the principal town of an island of Greece, the island of Skyros, had never seen a case of diphtheria in that place. In June, 1884, Dr. Paulinis was called to treat seven children affected all at the same time with diphtheria; five died. The epidemic spread over the town. In five months one hundred and twenty-five persons were affected, of whom thirty-six died. An investigation was made to ascertain the cause of the sudden appearance of this malady. It was discovered that in the quarter where the children were affected was found a poultry-yard filled with turkeys that had recently arrived by boat from Salonica. All these turkeys presented false membranes on the soft palate, and perished, with the exception of one, which preserved a paralysis of the feet which completely prevented locomotion. In commenting on this observation, Dr. Vallin remarked that rain-water which descends from the roof should be diverted from wells, as this water carries with it the dejections of pigeons, swallows, and birds of all sorts which rest on the roofs. It is a popular opinion that the water from the roofs of houses is excellent. It is at least charged with putrescible excrementitious matters which infect the wells. Nothing proves that this water does not convey the seeds of diphtheria, nor that the birds of the poultry-yard do not sow the seeds of diphtheria on the dung-heaps of the farms.

In a clinical lecture on hemorrhoids, Professor Potain thus summarized the medical treatment of this affection: Above all, he said, measures should be taken to prevent inflammation, then to combat the congestion and

It is reported that Dr. William G. Eggleston, who has for several years been a member of the editorial staff of the *Journal of the American Medical Association*, has retired from that position.

hemorrhages which may result. Of all the means extolled, the diet and regimen are certainly the most essential, that is to say, an active life and the avoidance of constipation, not by drastic purgatives, which would have the effect contrary to the object in view by augmenting the congestive state of the intestine and of the hemorrhoidal vessels, but by laxatives, of which the best are castor oil, the flowers of sulphur alone or associated with the cream of tartar, magnesia in small doses (fifty centigrams) every morning, so as to produce a regular movement of the bowels. But if the congestion is produced, and particularly if it is intense, rest in the horizontal position and astringents internally should be enjoined. Rectal irrigations and cold ascending douches without violence should also be administered.

Professor Jaccoud vaunts the free use of milk in the treatment of typhoid fever. Milk, he says, is an excellent diuretic, and when given internally it causes an abundant flow of urine. Professor Jaccoud reminds us that one of the first dangers of this malady consists in the insufficiency of the quality and quantity of the urine. The milk administered to these patients, from one and a half to two liters per day, renders urination sufficient, and at the same time supports the strength of the patient. Against the fever M. Jaccoud employs quinine and cold lotions with aromatic vinegar. He prescribes from four to eight lotions all over the body, according to the temperature of the patient. When the patient is exceedingly depressed or in a languishing state, he prescribes a mixture composed of four grams of the extract of cinchona and eighty grams of cognac to raise the strength of the patient. In the cases of weakness of the heart he prescribes digitalis. By these different means M. Jaccoud affirms that he has obtained the greatest success at La Pitié Hospital.

Dr. Geneuil states that for the last twelve years he has treated with success the most obstinate cases of epistaxis by means of nasal injections practiced with pure lemon juice. This remedy has constantly succeeded, even when other hemostatics had absolutely failed. He commences by washing out the bleeding nostril with cold water by means of a glass

urethral syringe; he then injects immediately, with the same instrument, a syringe-ful of lemon juice freshly expressed. At the end of one or two minutes the blood ceases to flow. It is rare that a second injection is necessary.

According to a note reproduced in the *Journal de la Santé*, after certain researches, Dr. Alfonso Montefusco has arrived at the conclusion that scillitine does not possess diuretic properties. It determines a diminution in its strength and frequency, the contractions of the heart and a lowering of the sanguineous pressure. Injections of this substance diminish the frequency and the strength of the respiration. It has no action whatever on sensation and on motility.

Drs. Betremieux and Vassaux state that, of all the antiseptics known, boric acid should be preferred for the treatment of diseases of the eye. At first carbolic acid used to be employed, but it was soon discovered that this acid irritated the eye. Corrosive sublimate and the biniodide of mercury were then resorted to; but these two products having the inconvenience of troubling the liquids of the eye, a concentrated solution of boric acid was adopted with very good effects. The authors therefore recommend that this solution should be employed in preference to all the collyria in a great number of the affections of the globe of the eye or of the lids. Five or six lotions per day, which should be hot, are necessary to obtain the excellent results furnished by boric acid.

Mushrooms of a good quality, that is to say, those which have not a toxic action, contain a good deal of nitrogenous matter, and are very nutritive. This is a fact so well known, and a popular idea affirms that a dish of morils, for instance, is equivalent to a good slice of beef. We are informed, in a note to *La Nature*, that M. T. Monner, a German physiologist, has fully studied this problem, and the following are his conclusions: To replace a soft-boiled egg, it is necessary to eat about half a pound of mushrooms, three-quarters of a pound of morils of the first quality, and one pound and a half of ordinary mutton. To take the equivalent of an ordinary beefsteak the proportions would be: mushrooms, five kilo-

grams; morils of the first quality, fourteen kilograms; morils of an ordinary quality, twenty-six kilograms. If we descend to the mushroom named "*polyporus ovinus*," it would require forty-one kilograms. A French writer, commenting on this subject, gives the following salutary advice, viz., that we should do well to adhere to the old custom, that of employing mushrooms only for flavoring or seasoning other dishes.

The *Moniteur Therapeutique* publishes a note on the incompatibility of the chlorate of potash and the iodide of iron. This incompatibility was revealed by the death of a child which fell a victim to it. The author remarks that these two substances, in reacting between them, yield the sesquioxide of iron; the chloride of potash and iodine is entirely set free.

PARIS, May 10, 1889.

## Abstracts and Selections.

**THERAPEUTICS OF SULPHUR.**—*Physiological Effects.* On the alimentary canal sulphur acts as a stimulant to the normal peristaltic movements, and in moderate doses becomes a laxative. It is probable that the stomach itself is little influenced by the sulphur, as the surface and contents of that organ are usually acid in reaction, and possess no solvent power; but when it arrives at the duodenum, and meets with a different condition of the mucous membrane and the presence of bile and pancreatic fluid, both alkaline in reaction, more or less of it becomes converted into a soluble sulphide, which is absorbed by the portal vessels, and passes first through the liver and afterward into the general circulation by the hepatic vein. From the blood it afterward becomes eliminated partly by the skin and partly by various mucous membranes. We have good evidence that it is thrown out by the skin in the fact that silver worn close to the surface becomes blackened to some degree when sulphur is taken continuously, and the odor of sulphureted hydrogen can occasionally be detected in the breath. The presence of the cream of tartar in the lozenge helps to prevent the formation of any soluble sulphide in the stomach, and hence the absence of sulphurous eructations. Any soluble sulphur, however, which reaches the cecum and colon, where the reaction is again acid, is apt to evolve hydrogen sulphide, and impart odor to the contents of the lower bowel.

*Therapeutic Effects on the Alimentary Canal.* As the alimentary canal is influenced partly by the direct action of the sulphur on its mucous membrane, partly by the circulation of the sulphureted blood through the intestinal capillary system, and partly by the altered and increased flow of bile from the liver, it will be naturally expected that in morbid states of this canal we should be able to detect marked effects from the continued administration of the remedy.

When commencing the use of the small doses of sulphur, I scarcely anticipated that any appreciable laxative effect would be produced by them; in this, however, I was mistaken, and although the word purgative is too strong to be applied to the action of a single lozenge taken at bed-time, still, in the majority of cases, it is sufficient to prevent the necessity of ordinary aperients being administered. In several instances I have known distinct purgative effects produced by the five grains of sulphur given in the form of the lozenge; but this may be looked upon as exceptional.

That the secretion from the liver is increased in cases of sluggish action of that organ is often very noticeable in the altered character of the feces; many patients have informed me that under the influence of the drug their motions have been brought from a pale clay color to the normal state; and although the action of the sulphur is slow compared with that of mercury, still in chronic torpid conditions of the liver the advantage of the sulphur over the mercurial treatment is undoubted. When we consider that the most important salt of human bile—namely, taurocholate of soda—is a sulphur compound, and one containing a large percentage of that element, it might almost have been anticipated that the administration of sulphur for a long time would produce a marked alteration of the biliary secretion. In the case of sodium, the other ingredient or base, which is united with both the taurocholic and glycocholic acids, we have good evidence that its influence on the secretion of the bile is well marked; hence in hepatic and stomach disturbances we usually select sodium salts in preference to those of potassium or lithium; hence, also, the value of Vichy, Marienbad, and Carlsbad waters in the treatment of chronic hepatic diseases. It is probable that the alimentary canal is more affected by the secondary action of the sulphur upon the intestinal glands than by the direct action of the drugs, and that the increased peristaltic effect is dependent to a great extent upon the increased glandular secretion. In hemorrhoidal conditions not suitable for surgical interference, and in some cases of bleeding from the rectum, I have seen the most marked beneficial effects from the

continuous sulphur treatment; the bleeding is often completely stopped, and great relief of all the symptoms obtained, especially the accompanying pruritus.

A horse artillery officer returned from India suffering from hemorrhoids to an extent which almost incapacitated him from performing his military duties. As it was not practicable for him to have any surgical operation at the time, I suggested he should take a sulphur lozenge each night for some months; he did so, and at the end of four months had recovered so completely as to feel equal to return to India and resume active duties.

Another case recently seen is of some interest. A middle-aged lady gave the following history of her ailment: For many years she had suffered from attacks which were called hepatic colic, and in the intervals of the severe attacks she had constant trouble, evidently connected with the imperfect action of the liver. She had been to Carlsbad and Vichy several times, usually with more or less advantage, but with no approach to a cure. After treating her for the discomfort she was at the time suffering from, I ordered the sulphur lozenge to be taken each night for many months—in fact, till her return to town. I saw no more of her for ten months, and then found that she had persevered with the treatment and had wonderfully improved; the attacks of colic had gradually lessened both in frequency and severity, and were practically removed; and her last visit was more for the purposes of inquiring if she might still continue the use of the lozenge than from need of further treatment.

I have been told by some few patients that they have experienced much relief from the lozenge in regard to a chronic discomfort of the throat (probably pharyngeal), which had either alternated with or accompanied a morbid condition of the rectum. My case-books furnish me with numerous cases in which the long-continued use of small quantities of sulphur has proved of great value in chronic diseased conditions of the alimentary canal, but I think what I have already stated is sufficient to direct the attention of the profession to the subject. Scarcely a day passes in which I am not told by some one or other of the great benefits experienced from the use of the lozenge; and it is not unusual to find that if prescribed for one member of a family they are soon taken by several others.

*Diseased Conditions of the Pulmonary Passages.* That sulphur, after being absorbed into the blood, acts upon other mucous membranes besides those of the alimentary canal and its appendages is not only probable but is made evident by the fact that the odor of sulphureted

hydrogen can sometimes be detected in the breath; and experience has shown that certain forms of bronchitis, especially when in aged persons and very chronic in character, are beneficially influenced by the administration of the drug. Formerly a very disagreeable preparation was used for the purpose; it was called the balsam of sulphur, and consisted of sulphur dissolved by the aid of heat in olive oil. Now that the remedy can be so readily given in the form of the lozenge, it might be desirable to make some extended trial of it in these troublesome affections.

*The Mucous Membrane of the Urinary Tract.* My experience as yet will not enable me to say much on the value of sulphur in certain forms of cystitis. In some affections of the kidney it is far from being contra-indicated, as its influence on the skin would tend to relieve any congested state of the renal organs.

*Diseases of the Skin and its Appendages.* The popular idea of the value of sulphur in affections of the skin is probably founded on experience, and if any argument is required to add to the probability, it is the fact that when taken for any length of time, even in moderate doses, it is eliminated from the skin in a very appreciable degree. In acne, psoriasis, and prurigo it is useful either given alone or as an adjunct to other treatment; also in some of the localized forms of eczema, especially those connected with a gouty diathesis, as pruritus and; is often most useful in allaying the very troublesome itching of that complaint—an effect probably due in part to the action of the sulphur on the skin, and in part also to its action on the hemorrhoidal vessels. Under the influence of small doses of sulphur, when long continued, the complexion of the patient often improves to a marked degree.

Not long since a lady who has taken the sulphur lozenge for nearly three years told me as a fact, what I little anticipated, that after she had continued the remedy for a short time her finger-nails, which had for long been accustomed to split very readily, so as to become very troublesome, ceased to do so; but when she omitted the use of the sulphur the brittleness returned. Again on resuming the use of the lozenge the nails became healthy, and have now remained so for two years.

If the growth of the nail is altered by the exhibition of sulphur, it is not probable that the hair, another cutaneous appendage, may be also influenced by it? It is certainly worth while to watch and see if an effect of any kind is produced on the growth of the hair under these circumstances. At present my experience will not allow me to give any definite answer to the question.

*Morbid Conditions of the Muscular System.*

From time immemorial sulphur has been employed as a remedy in chronic muscular rheumatism, and among the peasantry it is not uncommon to find that flowers of sulphur suspended in gin are made use of; the spirit may sometimes assist the action of the remedy, and often is an inducement to perseverance in the treatment. It is in such forms of muscular affections, which are benefited by guaiacum, serpentary, and such-like stimulants, that sulphur is found to be most efficacious. In cramps, so common in gouty subjects, the administration of sulphur is often very valuable, and I find in one of my case-books an entry to the effect that a gouty patient suffering from many of the so-called irregular forms of the disease is, among others, very subject to cramps; but these are quickly relieved and completely kept at bay by taking the sulphur lozenge.

*Chronic Articular Diseases.* It was for the treatment of the disease formerly designated by the name of rheumatic gout, but now called rheumatic arthritis, that I first prescribed sulphur in small and continuous doses. At that time I had no idea that it would prove so valuable in morbid states of the alimentary canal, my object being simply to bring the system under the influence of the drug, and thus endeavor to alter the morbid condition of the articular strictures. From my experience, I feel convinced that sulphur is useful in some chronic affections of the joints, although as yet I can not say I have depended altogether on the remedy, but have made it only a part of a therapeutic plan, in which it has been often associated with powerful agents, such as iodine and arsenic. The more chronic the form of the articular disease the more likely is sulphur to prove beneficial. In true gouty states of the joints, when the disease is both chronic and asthenic, sulphur is often a valuable adjunct to other remedies.

Up to the present time I feel that I can not speak confidently of the amount of benefit which is derived in chronic articular affections from the influence of the sulphur apart from other remedies. That it is valuable as an adjunct I have no hesitation in asserting, and that it often enables us to avoid the administration of purgative medicines is of itself a great desideratum.

*Summary.* (1) The results contained in the present communication were derived from the administration of very small doses of sulphur continued for a lengthened period of time; the doses being much smaller than those hitherto employed, often not exceeding five grains each day; and the time of exhibition much longer, namely, weeks, months, and in some cases

years. (2) A lozenge, named the compound sulphur lozenge, containing five grains of sulphur and one of cream of tartar, was usually prescribed, as being very convenient and by no means unpleasant in taste; and it was found that patients could be readily induced to persevere in using them for an almost indefinite time. (3) The physiological effect of these minute doses of sulphur are observed upon the alimentary canal and the organs connected with it; also on the pulmonary mucous membrane and the skin. (4) Sulphur is not an element foreign to the system, as it is contained in the most important proximate principles of the blood and flesh, and likewise of the bile and saliva. (5) Sulphur given in the manner above described is of great value in many morbid states of the alimentary canal and liver, as in cases of hepatic sluggishness and in piles and hemorrhoidal hemorrhage; besides which the continued use of the lozenges is often quite effectual in obviating habitual constipation without producing the unpleasant action often pertaining to ordinary aperient medicine. This beneficial effect on the bowels has doubtless been the chief cause of the lozenge having become so much liked, so continuously persevered in, and so extensively used. (6) Sulphur in small doses is sometimes useful in affections of the pulmonary mucous membranes. (7) Sulphur has long had a reputation, and doubtless is of much value, in many diseases of the skin and its appendages. (8) Some arthritic diseases, especially chronic forms of rheumatoid arthritis and gout, and also many cases of muscular rheumatism, are much benefited by the continued use of small doses of sulphur.

In conclusion it may be mentioned that the use of the compound sulphur lozenge, since first employed (not five years ago), has spread most widely; and I have been informed that one maker of medicinal lozenges has, during the last six months, sent out three hundred weight, which is at the rate of about two hundred and twenty thousand lozenges a year. Without wishing to lay too much stress on the value of the treatment I have been speaking of in the present communication, or of being thought to consider sulphur applicable as a therapeutic agent in more than a limited number of diseases, still of one fact I feel confident, that there are many hundreds at the present time who are indebted for much health and great comfort to the use of this simple and harmless remedy.—*Sir Alfred B. Garrod, London Lancet.*

**ATROPINE AS A REMEDY FOR SHOCK.**—Under this head Dr. Frank C. Bressler, of Baltimore, has a brief communication in the

Therapeutic Gazette for April, 1889, in which he refers the primary seat of shock to the nervous centers in the medulla oblongata. He claims that shock is not only a depression of the circulation, but in every case involves the cardiac, respiratory, vaso-motor, and secretory centers, so far as they exist in the medulla oblongata, and consists in a sudden molecular disturbance in those centers of greater or less severity. It is not claimed that all these centers are equally disturbed in every case of shock. On the contrary, in some cases the cardiac and vaso-motor functions are chiefly affected, and in others the respiratory suffer most, as it did in the case related by Dr. Bressler; and in choosing remedies we should be guided by the special predominating feature of each case. The correctness of the claim that *all* cases of shock have their primary seat in the medulla oblongata admits of some doubt. Cases of shock derived from blows or severe injuries in the epigastric region especially have been characterized by such extreme depression of the vaso-motor influence over the circulation, while the respiratory and mental functions were much less disturbed, as to suggest the thought that the primary seat of molecular disturbance was in the semi-lunar and other abdominal ganglia of the sympathetic system of nerves, and only reached the cerebro-spinal centers secondarily through the connecting links with those centers.

Granting the correctness of the position that the alarming condition recognized as *shock*, whether produced by mental or physical influences, consists in a direct depression or impairment of the function of one or more of the important nervous centers, in choosing remedies it is of much practical importance that we keep in mind two facts: (a) that a large percentage of cases of shock have recovered without any remedies, except fresh air and rest, and many more have done so in opposition to the injudicious remedies used; and (b) that when medicines are required they should be such as are capable of increasing either nerve force or nerve sensibility, or both, and not mere anesthetics that, while quieting restlessness, actually diminish both sensibility and activity in the nerve centers. But this distinction is entirely lost sight of by the people and a large portion of the profession, as we see in the almost universal resort to alcoholic liquids as the first, and in many cases the only remedies in such cases. And yet no fact is better established than that alcohol is as direct an anesthetic as is chlo-

roform or ether, and as certainly diminishes both the sensibility and activity of the nerve centers, even to the degree of entire paralysis if the administration is continued sufficiently active. As an illustration of this general tendency to confound anesthetics with nerve tonics, Dr. Bressler himself commenced the treatment of the interesting case he relates by administering brandy, both by hypodermic injection and by the mouth, but finding "no improvement," and the "breathing becoming shallower," he abandoned its further use, and his patient was given  $\frac{1}{10}$  grain of sulphate of atropine by hypodermic injection; and the same was repeated five minutes later, and in less than five minutes more the "breathing began to get freer, the pulse became fuller," and the improvement continued until all alarming symptoms had disappeared. Had he continued to multiply the doses of brandy, its anesthetic effect might have extinguished what remaining respiratory nerve force the patient had, and both friends and physician would have excused the death on the supposition that they had not been able to commence the use of the remedy early enough, as has often been done in times past. We are fully satisfied that the class of remedies to which atropine, digitaline, strychnine, caffeine, theine, etc., belong afford us the most efficient means for relieving shock, and all instances of sudden depression of the respiratory, cardiac, and vaso-motor nerve functions. When not readily administered by the mouth, they can be used efficiently by hypodermic injection or by rectal enema suspended in either water or milk as warm as the rectum will tolerate. *Journal American Medical Association.*

GONORRHEA CURED BY THE USE OF THALLINE. —Thalline is a synthetic alkaloid with properties intermediate between kairine and antipyrin. In the Dublin Journal of Medical Science, March, 1889, Dr. McCaw relates a case in which a rapid cure of acute gonorrhea was wrought by the application of bougies of thalline sulphate. The patient came for treatment four days after connection. He had an abundant yellowish-green discharge from the urethra, with severe pain during micturition, and great tenderness all along the urethra. The night before he applied he had to rise five times to pass water. Having had gonorrhea seven years before for two months, he looked forward with anxiety to a disagreeable course of opium drinking. Dr. McCaw treated him by the

introduction of bougies containing sulphate of thallin, five per cent. Having made the patient micturate, he passed the bougie up to the ring, and had the patient hold the meatus tight, so that the medicament could not escape as it melted. After he had lain on his back twenty minutes, the spring was withdrawn, and the meatus was closed with cotton wool. The presence of the bougie caused pain, which ceased after withdrawal, the patient feeling comfortable. The patient introduced a bougie every evening, and on the third day stated that he was cured, as he had no discharge and no pain on micturition. Being on his feet at work all the following day, and neglecting to use the bougie, he perceived a slight return of his symptoms on the next morning; but after using two bougies he was again cured, and for a week or more had had no second relapse, although busily at work each day.—*Maryland Medical Journal*.

THE NETTLE AS AN EPISPASTIC.—In the *Meditsinskoié Obozrenië*, No. 16, 1888, p. 330, Dr. Vladislav A. Frankowski, of Kharkov, whose medical experience embraces about one hundred thousand cases, speaks enthusiastically of "urtication," that is to say, slapping or pricking with a bundle of fresh nettle-twigs for one or several minutes, once or several times a day, as an excellent epispastic application. It has considerable advantages over ordinary derivative remedies, inasmuch as it is quite innocuous (not irritating the kidney and leaving no permanent marks on the skin, etc.) cleanly, simple in application, rapid in its effect, and cheap. Dr. Frankowski recommends it especially in (a) anesthesia, paralysis, and neuralgia, especially sciatica of peripheral origin as well as in incipient tabes, where he applies the nettles directly to the parts affected; (b) in dyspnea depending upon cardiac or vascular disease, where "general urtication" (that is, pricking along the vertebral column and over the whole abdomen and chest) is said to "relieve the agonizing symptoms far more rapidly and more completely than any other epispastic does;" (c) in respiratory diseases, spinal and thoracic urtication soon allays cough, promotes expectoration, relieves oppression, and produces a striking, though only temporary, improvement in the subjective condition; (d) in amenorrhea, urtication of the lumbar, sacral, and internal femoral regions excites the menstrual flow, even when employed alone, without any adjuvant; (e) in impotence, pricking the loins, sacral region, and genital parts is also of great service; (f) in rheumatic, muscular, and articular pains, urtication, com-

bined with cold bathing, is often far more useful than any thing else; (g) in syncope, asphyxia, concussion of the brain, coma, etc., energetic general urtication is an invaluable resuscitating measure which has been successfully resorted to by the peasantry all over Russia from time immemorial.—*British Med. Journal*.

SUPPURATING FIBROID POLYPUS.—On February 12, 1887, Dr. Lindfors, of Lund, Sweden, was sent for to attend a woman, aged forty-four, at Tvedörä, several miles from his residence. It had been reported that the uterus had prolapsed and could not be reduced. On entering the patient's room he was struck by the intensely fetid odor which pervaded the apartment. He examined the patient and discovered a tough, purple, pyriform mass the size of a fetal head protruding from the vulva. It was bathed in fetid, sanious pus. The mass had protruded for two days in this manner. After careful cleansing of the parts, Dr. Lund made a bimanual exploration. The tumor proved to be a submucous pedunculated myoma, springing from the body of the uterus, which was partially inverted. The fundus was felt to be concave. The pedicle was as thick "as a man's arm close to the wrist." The woman was feverish and much reduced in strength. Dr. Lindfors, who published this account of the case in the *Centralblatt für Gynäkologie*, February 9, 1889, felt that he could not safely remove the patient to Lund, considering that her condition was very bad and the weather wintry. He decided on operation—to remove at once the sloughy, septic tumor. His pocket-case included all the instruments at hand. A doubled silken ligature was tightly bound round the pedicle; then the latter was carefully cut through with scissors. There was little hemorrhage. The stump of the pedicle retracted itself directly it was divided. No attempt appears to have been made to reduce the uterus. During convalescence there was much sanious discharge. The patient's daughter kept the parts clean with carbolic injections. On March 24th the patient left her bed quite well. On June 23d Dr. Lindfors examined the pelvic viscera. The cervix was normal, the body of the uterus small and in place; no trace of the tumor could be detected. The patient menstruated regularly. Dr. Matthews Duncan and other British operators advocate simple division of the pedicle as a perfectly safe and efficacious procedure even in large polypi, as in this case.—*Ibid*.

# The American Practitioner and News

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D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } - - - Editors.

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## SOME LIGHT ON CANCER.

Than cancer, the nosological category has no disease that has been more thoroughly studied, clinically, pathologically, and therapeutically, nor any which has yielded under such study more discouraging results. To this date the etiology of cancer and its nature are unsolved mysteries; it is still doubtful if heredity predisposition has aught to do with determining its development in any case, while the theory of its contagious character has, till now, received no support from physiological experimentation. These considerations, together with the undoubted fact that the disease is rapidly on the increase in Europe and America, the frightful operations which are often undertaken for the temporary relief of its victim, and the prognosis of despair which at last must be made in the majority of cases, clearly entitle it to the chief place among the furies whose office it is to scourge mankind.

It is therefore with uncommon interest that we learn that Hanau, of Zurich (*La Semaine Médicale*), has succeeded in transferring the carcinoma of a rat afflicted with papillar canceroid to two animals of the same species. The inoculation of an animal with cancer has hitherto been considered an impossibility. Success in this case will give stimulus to re-

newed study, and gives hope that the etiology of the disease may yet be mastered.

A vital point in the treatment of cancer, though not new, was given due emphasis by Prof. Heidenhain at the Eighth Congress of the German Society of Surgery, held in Berlin, April 24th to 27th. In some remarks on the causes of the local recurrence of cancer after extirpation of the breast, he said that "in all cases where there was afterward recurrence he had been able to convince himself, by microscopical examination, that particles of cancer had been left in the wound during the operation. Sections of apparently sound tissue in the vicinity of the morbid tumor revealed *epithelial trails* infiltrating the parts. These epithelial trails follow the lymphatic vessels and sometimes extend to the aponeurosis of the pectoral muscle." Heidenhain had studied eighteen cases in which the breast had been extirpated for primary cancer. In six of these he found the tissue surrounding the tumor free from epithelial infiltration, and in these the disease has not returned.

Since the lymphatic vessels which constitute the channels of infiltration run perpendicularly down into the pectoral fascia, this structure, with sometimes a part of the muscle itself, should always be removed with cancer of the breast. Küster has long followed this practice. Cancers of the breast when adherent to the pectoral aponeurosis are always of bad prognosis. Of Von Volkmann's sixty-five cases in which this adhesion was noted, but two of the patients failed to suffer recurrence of the disease.

While the crumbs of comfort found by the pathologist in these observations may be never more than crumbs, the practical surgeon will find excuse for enthusiasm in the rosy prognoses of cancer under treatment which the discussion at the Congress brings to view.

As the Boston Medical and Surgical Journal puts it, the following delightful showing was made:

"Von Bergmann presented a case of carcinoma of the pharynx operated upon in 1884; three months afterward disease returned, when complete extirpation of the glands was effected; since then the patient has remained free from

cancer. A case of cancer of the face, extirpated four years ago, no return; two cases of cancer of the lips, operated upon two years ago, no return. Thiersch, of Leipzig, some time ago operated on cancer of the stomach; there had been no return. Koerte, of Berlin, two years ago extirpated a cancer of the larynx; the patient has had no recurrence. Von Bergmann said that four years ago he removed half the larynx for cancer. The patient had remained well to the present time. Schmidt, of Frankfurt, three years ago removed the entire larynx for cancer; no recurrence; Schmidt, of Stettin, had also removed, two and a half years ago, the entire larynx for cancer; the patient recovered and kept well; he breathes through a canula. Von Esmarch stated that twenty years ago he operated on a case of cancer of the tongue; the patient remained free of his cancer; recently he died of apoplexy. Schebe, of Hamburg, had operated on three cases of lingual cancer; after several years there had been no recurrence. Von Bergmann presented a case of cancer of the tongue operated on two years ago, and another operated on four years ago; both had remained well and exempt from recurrence. Küster and Krause had had similar cases. Of cancer of the rectum, three cases were communicated by Krause; extirpation was performed six, eight, and nine years ago; all are now free from the disease. Bergmann presented a patient on whom the 'high amputation' of the rectum for cancer had been performed four years ago; no recurrence. Schinzinger, of Friburg-in-Bresgau, reported that he had operated on eighty-six cases of cancer of the breast; in twenty-six only there had been a return in the course of a couple of years."

### Notes and Queries.

INDIANAPOLIS CORRESPONDENCE.—The event of interest is the fortieth annual meeting of the Indiana State Medical Society, which was held at Plymouth Church, May 1st and 2d, under the presidency of Dr. W. H. Wishard, of Indianapolis.

An interesting paper on Myxedema, with re-

port of case, was read by Dr. Jas. F. Hibberd, of Richmond, Ind., at the meeting of the Indiana State Medical Society. His patient was a lady, aged fifty, previously slight in build; but although her general health had been failing during several months, her weight was one hundred and forty-three pounds when she consulted him. She suffered from a sense of general weariness, abatement of mobility, disinclination to active exercise, and lessened ability to concentrate her mind on any important affair. Her skin had become dry, pale, and sallow, and was swollen and puffy, particularly about the feet and hands, but gave her most discomfort from the thickness and weight of her eyelids and surrounding tissues. Her limbs had lost their normal suppleness, and she walked with an unsteady gait; her hands were stiff and swollen, making it almost impossible to hold a pen or write. She complained of general subjective cold, and her temperature was found subnormal. She presented a depreciation of vital activity and a sluggishness of mental operations. Examination displayed no special error in respiratory, circulatory, urinary, or uterine functions.

The patient was advised to cease her literary occupations. Moderate outdoor exercise, with quinia, strychnia, and iron, soon brought a slow improvement in her condition, though she still presents a remnant of her serious ailments of two years ago. This is a typical case of myxedema, a mild attack of favorable progress and promising prognosis, but presenting all the characteristic symptoms of the disease.

The first description of myxedema was by Gull in 1874, and in 1876 Ord gave a thorough exposition of its leading characteristics, and proposed the name, as he declared mucin was found in the tissues of all its victims. Hammond gave a short description of the disease in 1881, and the treatises on General Practice since have had chapters devoted to myxedema.

The American Journal of Medical Sciences published two papers, in July and August of 1888, by Drs. Hun and Budden, giving thorough details of four cases under their observation and of the literature of the subject. Excluding cases due to the extirpation of the thyroid gland for disease and those associated with

idiocy and cretinism, there are one hundred and fifty-four cases of idiopathic myxedema more or less completely reported, according to their researches. The conclusions reached by them are: There are more than three times as many females affected as males; the average age for the beginning of the disease is forty years; chief etiological factors are, excessive child-bearing, excessive hemorrhage, mental shock and worry, and injuries, especially of the head.

Myxedema appears to manifest itself in very characteristic symptoms, which affect especially the cutaneous, nervous, and vascular systems.

**Cutaneous:** Skin swollen without pitting; dry, scaly, and cold; hair and teeth frequently fall out. The mucous membranes are swollen, but their secretion is increased, while perspiration is absent or greatly diminished.

**Nervous system:** Mental sluggishness and impairment, insanity frequent, impairment of sensibility in most cases; in all cases muscles act freely; numbness and neuralgic pains are often present.

**Muscular system:** Pulse usually slow and small, and heart presents some abnormality; blood often in an anemic condition; sometimes severe hemorrhages.

A clear, succinct, comprehensive statement of our present knowledge of this disease is found in the summary of Dr. Ord, printed in the *London Lancet*, June 2, 1888, and copied in the *Medical News*, Philadelphia, June 23d.

The author concludes with the statements that he thinks myxedema a distinct disease with well marked symptoms. Its diagnosis is easy and certain. It is not amenable to treatment, and persons affected with the disease never regain a perfectly normal condition. He thinks it quite possible to meet associated disturbances with remedies, and by proper use of exercise and rest to carry persons through years of comparative ease.

The address of the president was an interesting review of the practice of medicine during the past fifty years. He asked the question, Have we, as medical men, kept abreast of the times? His answer was a masterly effort in the affirmative. The primitive Indiana doctors had not advantages of education medically.

The Transylvania University, at Lexington, Ky., opened a medical department in 1817 which soon grew to be the second medical school of the United States. In 1819 the Medical College of Ohio, at Cincinnati, and in 1837 the Medical Department of the University of Louisville were formed. Only twenty to twenty-five of the physicians of Indiana had taken one course in medicine in 1825. Ephraim McDowell was not a graduate, but after he had practiced thirty years the University of Maryland gave him the honorary degree of Doctor of Medicine. The *Medical Repository*, of Philadelphia, was the only medical journal in the United States at the beginning of the early part of this century.

Dr. Lunsford P. Yandell, of Louisville, first instituted the treatment of fevers more in accordance with modern ideas. Dr. Wishard well remembers when quinine first came into use. He was given a prescription consisting of 30 grains of quinine, 10 drops of dil. sulphuric acid, and 6 ounces of water; dose, teaspoonful, to be taken three times a day with great care. He has known an old thumb lancet to descend as an heirloom in families for several generations, and it had drawn more blood than some regiments in the civil war. An old theory of mighty weight was, that if you drew blood from the right arm when pain was in the left the pain would be drawn across the heart and the patient would be killed. Obstetric business was, of necessity, in the hands of females in the early days. Physicians were scarce, women were robust, and hardy nature required but little assistance. Early settlers were almost exempt from tuberculosis, diphtheria, and cerebro-spinal meningitis. In winter, pleurisy and pneumonia raged. Four fifths of the cases had been treated by the old women until hopeless; then the doctor was called. The doctor was looked upon with suspicion in obstetric cases, and was not summoned until there was dire necessity; then the news spread like wild-fire, and the neighborhood turned out as to a wedding or a funeral. The good dame of fifty years ago would show with pride her ten or twelve sons and daughters. To-day we are shown one son or daughter and a poodle dog, sometimes only the poodle dog, as the hope of the family.

The doctor then made some scathing remarks on criminal abortion; and after some statements relative to the fortieth anniversary of the Indiana State Medical Society, which was organized June 6, 1849, with twenty-eight physicians, of whom only five are now living, his interesting address was closed amid applause.

The report of the secretary showed a gain of six county societies and seventy members over last year. No doctor can be a member of the State Society unless belonging to the county association, and being a member of the latter makes him a member of the State Society. The whole number of members is twelve hundred. The treasurer's report announced a prosperous condition of the financial affairs of the Society.

Dr. Kate Corey, a graduate of Michigan University and superintendent of the Methodist Hospital at Foochow, China, was introduced to the Society and made a brief speech. The motion to make her an honorary member was passed without a dissenting voice.

Officers elected: President, Dr. J. D. Gatch, Lawrenceburg; Vice-President, Dr. S. Y. Yonte, Lafayette; Secretary, Dr. E. S. Elder, Indianapolis; Assistant Secretary, Dr. T. C. Kennedy, Shelbyville; Treasurer, Dr. F. C. Ferguson, Indianapolis.

A paper was read by Dr. G. W. Vernon, of Indianapolis, on Broncho-pneumonia in Children. He thought the use of natural gas had become an important factor in this and catarrhal diseases. In treating measles, whooping-cough, etc., we should bear in mind the possibility of this disease. It may commence in the tubes and extend into the alveola, or may begin in the interstitial tissue.

Dr. Johnson, of Indianapolis, thought there were more recoveries from acute lobar pneumonia than from broncho-pneumonia. He considers catarrhal disease essentially belonging to childhood.

The Hydro-therapeutic Treatment of Typhoid Fever was the title of a paper by Dr. G. W. Smythe, of Greencastle, which was followed by a paper on Atypical Typhoid Fever by Dr. H. McCullough, of Ft. Wayne.

Dr. M. F. Porter thought there were more cases of the atypical than typical fever. He opposed the routine treatment by cold baths.

Dr. Mendenhall said there were 300,000 cases of typhoid fever in the United States each year, and 30,000 of these die. We should be interested in the disease. The discussion on the subject grew quite lengthy, and the conclusion was that the whole question was simply one of diagnosis.

Urethral Stricture in the Male was discussed by Dr. W. H. Wishard, of Indianapolis. Otis' operation is the only method by which he feels confident of success, as he is still dissatisfied with electrolysis.

Nervous Sick-Headache was the title of a paper read by Dr. A. C. Porter, of Lebanon. He said little was written and little known about this disease, though it is so frequent. He thought a large majority of cases due to a deficient supply of blood in the brain or some part of it. When owing to stomach trouble, bismuth and fluid extract of quassia are good.

Cholelithotomy was discussed in a paper by Dr. Miles F. Porter, of Ft. Wayne; A Case of Suppurative Peritonitis, by Dr. G. W. McCaskey, of Ft. Wayne; Glaucoma, by Dr. A. Blitz, of Indianapolis.

Nature and Etiology of Tuberculosis was the title of a paper by Dr. R. F. Stone, of Indianapolis, who opposed bacteriology and all the theories of Koch. He disbelieved in contagion, thought the germ theory a fallacious one, and antiseptics useful only so far as they induced cleanliness. This paper produced considerable discussion among the disciples of Koch.

LOUISVILLE SURGICAL SOCIETY.—At a meeting of this Society on the 27th ultimo, after the regular exercises, the Fellows and numerous invited guests partook of a supper given by Dr. H. H. Grant in honor of the Society's president, who is also president elect of the American Surgical Association. Speeches appropriate to the occasion were made by the host, the president, Drs. J. M. Mathews and E. R. Palmer.

LOUISVILLE MEDICO-CHIRURGICAL SOCIETY. At the regular annual meeting of this Society, May 31, 1889, Dr. J. M. Ray was elected president, Dr. A. M. Cartledge, vice-president, and Dr. W. L. Rodman, secretary and treas-

urer for the ensuing year. A notable feature of the occasion was a report upon the history of the Society by Dr. William Bailey.

The retiring president, Dr. Turner Anderson, took leave of his office in an able address, after which the speaker, who was also the host, sat down with the Fellows and many invited guests to supper.

Dr. E. R. Palmer acted as toast-master, and called forth speeches from the president elect of the American Surgical Association, and a number of representative medical men who were members of the Society, or present by invitation.

**TO THE MEDICAL PROFESSION:** The various medical associations and the medical profession will be glad to learn that Dr. John S. Billings, U. S. Army, has consented to take charge of the Report on the Mortality and Vital Statistics of the United States as returned by the Eleventh Census.

As the United States has no system of registration of vital statistics, such as is relied on by other civilized nations for the purpose of ascertaining the actual movement of population, our census affords the only opportunity of obtaining near an approximate estimate of the birth- and death-rates of much the larger part of the country, which is entirely unprovided with any satisfactory system of State and municipal registration.

In view of this, the Census Office, during the month of May this year, will issue to the medical profession throughout the country "Physician's Registers" for the purpose of obtaining more accurate returns of deaths than it is possible for the enumerators to make. It is earnestly hoped that physicians in every part of the country will co-operate with the Census Office in this important work. The record should be kept from June 1, 1889, to May 31, 1890. Nearly 26,000 of these registration books were filled up and returned to the office in 1880, and nearly all of them were used for statistical purposes. It is hoped that double this number will be obtained for the Eleventh Census.

Physicians not receiving Registers can ob-

tain them by sending their names and addresses to the Census Office, and, with the Register, an official envelope which requires no stamp will be provided for their return to Washington.

If all medical and surgical practitioners throughout the country will lend their aid, the mortality and vital statistics of the Eleventh Census will be more comprehensive and complete than they have ever been. Every physician should take a personal pride in having this report as full and accurate as it is possible to make it.

It is hereby promised that all information obtained through this source shall be held strictly confidential.

ROBERT P. PORTER,

*Superintendent of Census.*

DEPT. INTERIOR, CENSUS OFFICE,  
WASHINGTON, D.C., May 1, 1889.

**INCONTINENCE OF URINE IN CHILDREN.**—Dr. Simon Baruch, in the Archives of Pediatrics, April, 1889, claims considerable success in the treatment of this frequent and annoying affection with belladonna or atropine. To children from six to ten years of age he gives  $\frac{1}{60}$  grain of atropine about 4 o'clock P. M., and repeats it at bed-time, unless at that time the pupils are well dilated. He deems it necessary, for success in the treatment, that the child be sufficiently under the influence of the medicine to have the pupils dilated during the hours of sleep. *Journal American Medical Association.*

**ANXIOUS MOTHER:** "I wish, Susan, that when you give baby a bath you would be careful to ascertain whether the water is at the proper temperature." Susan: "Oh, don't you worry about that, ma'am. I don't need no 'mometers. If the little one turns red the water is too hot; if it turns blue it's too cold, and that's all there is about it!" — *Boston Commonwealth.*

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION recently added 75,000 extra to its regular edition. We sincerely hope that the enterprise of its management may be rewarded by the return of 75,000 *bona fide* subscribers.

**TAKE YOUR MEDICINE.**—Dr. C. R. Illingworth says, in the *British Medical Journal*: As is only too well known, children and infants frequently refuse to take medicines, however palatable they may have been made. A great deal of trouble may be saved, I find, by fixing the cheeks firmly with the finger and thumb of the left hand, while the spoon is inserted with the right. By this method, which I first observed practiced by a young married lady recently, the first essential in the act of deglutition is provided for, namely, a fixed point for the pharyngeal muscles. Ordinarily this provision is effected by closing the mouth, and there can not, I think, be any doubt that the prevention of the natural process by the presence of the spoon leads in great part to the struggle to avoid taking medicine. When the approximation of the lips is prevented by the firm forward pressure of the finger and thumb, medicine may be poured into the pharynx without fear of its being spat out, and the most refractory child will, as a rule, discreetly swallow it. The practice of nipping the nose should, I am sure, be strongly condemned, because of the risk incurred of forcing the medicine along the eustachian tube.

**STRUCK BY LIGHTNING.**—The daily papers state that contracts were signed May 7th, by which the State of New York purchased for the electrical execution of condemned criminals three Westinghouse alternating-current electric light dynamos. The State prisons at Sing Sing, Auburn, and Clinton are each to have one of these deadly machines, which will be driven by the engines already in place. The current will be applied to the unfortunates at the same pressure used by the system for electric lighting, and the State's experiments have shown that death will ensue in less than thirty seconds.

**MEDICAL SOCIETY MEETING.**—The Mitchell District Medical Society will meet at West Baden Springs, Orange County, Indiana, July 18th and 19th. A number of good papers will be read. Many of the leading physicians of Chicago, Indianapolis, Cincinnati, and Louisville will be present. Re-

duced hotel and railroad rates. John D. Simpson M. D., President, Bloomington; G. W. Burton, M. D., Secretary, Mitchell; J. Rawson Pennington, M. D., Res. Physician, Louisville, Ky.

**REMARKABLE ELASTICITY.**—In experiments recently made in France on the elasticity of cork, it was found that disks of that substance, when submitted to a pressure of sixty-six tons to the square inch, were compressed to one fifth their thickness, and recovered their original dimensions in exactly ten minutes after the pressure was removed.

**DR. HOWARD A. KELLY**, Associate Professor of Obstetrics and Diseases of Women and Children in the University of Pennsylvania, has been elected Professor of Obstetrics and Gynecology in the Johns Hopkins University, at Baltimore.

The hospital of the Johns Hopkins University, at Baltimore, was opened with appropriate ceremonies May 7th.

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### SPECIAL NOTICES.

**MESSRS. ELI LILLY & Co.**, of Indianapolis, have issued a work entitled *Hand-Book of Pharmacy and Therapeutics*. The aim, as stated in the introduction, is to furnish the busy practitioner a reliable means of ready reference, at once concise, systematic, and authoritative, to which he may refer with confidence in cases of doubt. Younger members of the profession and medical students will find this work full of suggestions. It will be sent free to any physician, druggist, or medical student, by addressing Eli Lilly & Co., Indianapolis, Ind., mentioning this journal.

#### *Messrs. Reed & Carnrick:*

**GENTLEMEN**—I have been much interested in the study of the milk question as it affects infants who are deprived of their mother's breast, and have discussed it editorially and otherwise. This summer I have had the question forced upon me practically, as the result of the illness of my wife, necessitating the weaning of our baby and supplying her with some artificial substitute. I have thus given a practical test of Carnrick's Soluble Food, and have been perfectly satisfied with the result, as our little one has thriven on that food, I think, as perfectly as if the mother had been able to nurse her. Though this has been her "second summer," she has not had any disturbance of digestion or tendency to diarrhea at all.

DR. E. M. NELSON.

ST. LOUIS, MO.

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÂ."

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[NEW SERIES.]

*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.*

## Original Articles.

### THE IMPORTANCE OF RECTAL EXAMINATIONS TO LIFE INSURANCE COMPANIES.\*

BY JOSEPH M. MATHEWS, M. D.

*Professor of Surgery, Kentucky School of Medicine.*

The importance of a thorough examination of an applicant for life insurance can not be overestimated. So well recognized is this that all companies aim to secure the services of competent physicians as examiners, yet many are passed who should not be. Whether this is from incompetency or from gross neglect we will not stop to argue. Be this as it may, certain is it that an injustice is done the company each time that an applicant is passed who is below the physical standard. So careful is the State of its citizens' welfare, that laws looking to their protection are passed by the legislature, and each company seeking to do business in any State must conform to those laws or be prohibited from doing business within its borders. In keeping with this, each reputable company seeks to protect those already insured from any imposition, hence a long list of questions looking to the confirmation of good health and a sound family history are asked, and the applicant is required to undergo a rigid physical examination. If he stands the test, he is accepted. If he does not, he is rejected. The reason for rejection is sometimes based upon that which the

longevity afterward proves to have been a mistake; as, for instance, the height of the individual must be in proportion to a certain measurement of the chest and abdomen, or to the weight of the body. Again, if an applicant shows a family history of tubercular trouble, he is liable to be rejected; or, if he has already a lung deposit, he is certain not to be recommended, notwithstanding the fact that many persons whose parents, one or both, may have died with phthisis, they have escaped the disease altogether. And it is also well known that phthical patients have been cured.

I do not cite these instances to condemn the action of the companies; but it must be conceded that the applicant must be protected in his rights equally with the company. If he is rejected, either through the incompetency of the medical examiner or through the fault of the company's rulings, he is forever barred from acceptance in other companies. The responsibility of the medical examiner for life insurance is a very grave one, and I am inclined to believe is often overlooked. The comfort, happiness, and even the lives of individuals may rest upon his decision. Each and all of us are more or less interested in this subject, and this forms my excuse for writing this paper.

There is a class of trouble to which very little attention is paid by life companies, the importance of which every one will admit, a class that is attended with more serious results than the majority of those mentioned in life policies. I allude to diseases of the rectum. I submit the following propositions:

1. That there are diseases affecting the rectum which are unrecognizable, save by a careful exploration.

\* Read at the May meeting of the Kentucky State Medical Society at Richmond.

2. That when syphilis or cancer attack the rectum they are usually incurable, hence end fatally.

3. That the interim between their incipency and full development is so vaguely marked that nothing less than a full exploration will reveal their nature.

4. That if, during this interim, the person should apply for life insurance, he would be accepted, other things being equal.

To elucidate my subject I have taken at random a few cases from my record-book.

CASE 1. Mr. C., about forty-five years old, came to me, at the suggestion of his physician, to be examined. He remarked that his doctor was not sure that he had rectal disease, nor was he certain; yet, because of the fact that if he strained at stool and passed a little blood and mucus, he thought it best to be examined. Placing him in a recumbent position in a good light, I carefully searched the rectum but found no disease. Removing the speculum I inserted my finger, and, asking the patient to strain, I was enabled to explore the gut for six or seven inches. At the end of the finger I detected an indurated spot which seemed to extend upward. Although there was no gland involvement I gave it as my opinion that this man had cancer. He was given treatment by injections, and in a few days the symptoms cleared up; no discharge of either blood or mucus at stool. After this he took a long journey. Upon his return he called at my office to say that he was well. I insisted upon an examination, but he refused. He had a rest from all bad symptoms for several months. During the interim he applied for a life policy of ten thousand dollars, passed the examination and was received. After a while his condition grew worse, the tumor could be felt through the abdominal walls in the sigmoid flexure. Perforation eventually took place, and he died of—cancer.

CASE 2. Mollie T., unmarried, about twenty-eight years old, of easy virtue, and gave a history of syphilis, though no evidence of it could be detected. Had had several abortions produced upon herself. Having money, she never wanted for the comforts of life.

She came to me to be treated for constipation. Upon examining her a close stricture was found, located about two inches above the external sphincter muscle. I advised her to let me divide it. She refused, but consented to gradual dilatation. This was practiced until a No. 8 rectal bougie could be passed. She then failed to report for a number of months. When I saw her again the stricture was as tight as when I first saw it. I should mention that after the first dilatation a large mass of fecal accumulation was passed. After the second treatment she again disappeared, and I did not see her for months. Meeting her on the street one day she said she was not doing well, and would call to see me soon. I warned her of the danger of neglect. She apprehended this, but failed to report, and in a few days went upon a long journey. A telegram was received on the morning of the third day after her departure announcing her death. Her physician wrote that she had died of perforation, the result of impaction.

CASE 3. A gentleman, aged thirty, consulted me for constipation. His history was very like many who suffer from this trouble. Said he had taken purgatives in all forms until he had lost all faith. I examined his rectum and found a close stricture at the entrance of the sigmoid flexure. He was put under chloroform, and by divulsion of the sphincters I introduced my hand and arm into the rectum, and by making a cone of fingers pushed them through and divulsed the stricture. He made a good recovery. During the time of his complaint he never lost a pound of flesh or refused to eat a meal.

CASE 4. Dr. B. asked me to see a young married woman with him. Had been constipated for a long time, but was now unable to have a passage from the bowel. An examination revealed a stricture, just above the external sphincter, which would not admit the entrance of the small finger. This stricture was freely divided, and she made a rapid recovery.

CASE 5. A young man brought to me by Dr. G. suffering with the following symptoms: frequent disposition to go to stool;

passes some mucus and blood. With the finger I could feel nodules four or five inches up the gut, too high for excision. Cancer was diagnosed. Under injections all bad symptoms disappeared. For months thereafter he appeared in good health, not losing a pound of flesh, and eating and sleeping well. After this the deposits gradually extended, strictures formed, there was glandular involvement, loss of flesh, bad color, etc., and the man is now dying of cancer.

CASE 6. A married lady, mother of six children, aunt of the last patient mentioned, apparently in good health, came to consult me for piles and constipation. An examination revealed several close strictures. These were divided; but a bad prognosis was given because I believed the case to be syphilitic. She has gradually grown worse; strictures reformed; has lost flesh; and it is only a question of a short time when she will die.

CASE 7. Mrs. P., the wife of a doctor, accompanied by her brother-in-law, who is also a doctor, came to me for some "trivial" rectal trouble. I found a scirrhus cancer blocking the rectum. She died in about eight months afterward.

*Remarks.* The first case verifies all four of the assertions that are herein made: (1) The disease could not have been recognized except by a thorough exploration of the rectum. (2) It proved to be both serious and fatal. (3) In the interim between incipency and development of the growth he secured a life policy for ten thousand dollars.

Case 2 substantiates the propositions as well, except no application for life insurance was made. It might be said that in this case a history of syphilis was given, and that this would have prevented an acceptance for insurance. I would answer that in many cases of syphilis the only local manifestations are found in the rectum.

The other cases cited show how easily the most dangerous form of disease in the rectum can escape notice. In conclusion, I believe that, by requiring an examination of the rectum, life companies would save thousands of dollars annually.

## INCISED WOUNDS.\*

BY CORNELIUS SKINNER, M. D.

*Professor of the Principles and Practice of Surgery, Hospital  
College of Medicine, Louisville.*

In dealing with a subject of much importance to the surgical profession and under circumstances which necessitate few words, it is impossible to take up all forms of wounds, therefore this article will be confined to one of the most frequently seen varieties, viz., incised wounds. In this day of operative surgery when every man aspires to distinction as a rapid and bold operator, strange as it may seem, this most important part of the work, which is so influential in the prognosis, is passed rapidly through, or even assigned to some unskilled assistant to look after and report on at irregular intervals. The fact that incised wounds are often made by accidents, or made while the individual is engaged in a personal encounter, as well as by the surgeon's knife applied for various purposes, naturally divides the subject into two heads, viz., (1) Surgical or Aseptic; (2) Accidental or Contaminated Wounds.

Starting out, then, with these two varieties of wounds, and one goal before us, the surgeon will be counted most successful who conducts the largest per cent of cases safely into it. The first step in the proper management of a wound is to recognize or admit the existence of sepsis, or putrefaction, as opposed to asepsis.

The older writers taught that there were five ways for wounds to unite "or heal;" today we only recognize two, one without pus, or by first intention, another with pus, or by granulation.

It is a well-recognized fact that a wound heals quicker by the first process, and that less damage results to the tissue by the formation of the minimum amount of cicatrix, therefore our aim is to get in all wounds union without pus. What a smile of satisfaction plays over the countenance of the surgeon when he finds by inspection that this order of things has been obtained! Re-

\* Read at the May meeting of the Kentucky State Medical Society, at Richmond.

cent observation in this field has proven to us that properly managed wounds heal only in this way, and that to-day no such thing as laudable pus exists. Taking up, then, that first variety, or surgical wounds, the first step consists in maintaining asepsis, and this is done by preserving absolute cleanliness in every detail of the operation. The patient, surgeon, assistants, bowls or basins, sponges, instruments, etc., should be thoroughly cleaned in hot water and afterward washed in a solution of carbolic acid, two per cent, or 1-1,000 of bichloride; all water used for solutions and other purposes should be first boiled. By all means, during and after the operation, the wound should be well irrigated with a hot solution of bichloride coming from a jar suspended sufficiently high to allow the water to be thrown with some little force upon and through the wound. Being now assured that all hemorrhage has ceased, our next step is to bring the opposed surfaces into contact by sutures of well-prepared catgut, at the same time making provision for drainage, either with a rubber tube or bunch of catgut sutures passed through the wound; the sutured tissue is to be dusted with powdered iodoform, and directly over the line of apposition is placed a strip of rubber tissue to extend not more than half an inch beyond the stitch holes; over this tissue is to be placed a pad of iodoform or moist bichloride gauze surrounded by a third layer of absorbent cotton, or, better, wool. Lastly, the whole to be inclosed by a number of turns of moist bichloride gauze bandage. This constitutes the modern dry dressing, which converts the wound into an artificially-made, subcutaneous one, the idea being borrowed from nature, in that it has been a long-observed fact that nearly all subcutaneous wounds heal without pus. This primary dressing, when there are no stitches or drainage-tube to be removed, is allowed to remain until complete union has taken place, time varying from ten to forty days, unless its removal is prompted by one of three things, viz., hemorrhage, pain, or pus, the first two being easily recognized, the third by a chain of

symptoms, pain, elevation of temperature to or above 103°, not controlled by quinine, thirst, restlessness, etc., possibly one or a series of chills.

By following these simple rules we preserve the two great laws governing healing of wounds, viz., rest and position. Meddlesome or too frequent dressing is annoying to the patient, exposes the wound to external contamination, and in many cases will break up a considerable portion of the adhesions, thereby delaying perfect or firm union.

The second variety taken up by the paper is composed of those which are made by accident, and into which foreign substances have gotten, as dirt, hair, etc. Since we desire union without pus, or by first intention, which can be obtained only in aseptic wounds, our first step in the management will be to perfectly cleanse the wound of all foreign material, check the hemorrhage, and lastly cleanse by means of the irrigator mentioned above, coaptate the edges, and dress as in all other aseptic incised wounds. But whenever there is any possible suspicion of septic material being left or retained, proper drainage should be provided for, and the moist dressing instead of the dry is to be used, which consists of dusting the surface with iodoform powder and applying directly to the wound a pad of moist gauze of bichloride five or six layers thick; this should be covered with a thick layer of wool or cotton, also moist. No protective, you will observe, is applied to the surface of the wound, which is confined by a number of turns of bichloride gauze bandage, but the whole mass of material is covered with oil paper or *silk* to retard evaporation and keep the dressing moist for a longer time. If, by virtue of a large area of cutaneous surface inclosed with an impervious outer layer of paper or silk, the part becomes hot, this layer can be dispensed with, and the dressing moistened at intervals with a 1-3,000 solution of bichloride. The moisture answers the double purpose of keeping down inflammation and rendering the dressing much more absorbent, by causing it to take up the discharges

rapidly, just as a sponge will become saturated much more quickly after being once moistened. The moist dressing, when the wound is suppurating, is to be replaced every day, or as often as the dressing becomes disagreeable or soiled with pus. The moist gauze will be easily removed from the surface, there being no stitching. Cotton should not be applied to the surface, as it often comes away in small pieces and we are liable to leave some adhering to the granulations which acts as an irritant. Not only is it necessary to protect the wound from contamination at the moment of its infliction, but each subsequent dressing is to be made under the same antiseptic precautions. All materials to be applied are to be made ready and placed in easy reach. Irrigation fluids, basins for the reception of soiled dressings, and a well-trained assistant should be at hand.

The patient is now placed in a good strong light and the old dressing removed. Fatal mistakes have been made by unnecessarily long exposure of wounds to the atmosphere, and no dresser can do the work well when working in the dark. It is well to allow the irrigator to play over the surface all the while during the removal of the dressing, as it loosens up the material and washes off all foreign matter. Lastly, and by no means of small importance, dressers should be well drilled in the manipulation of bandages and dressings. Gentleness and dexterity are two indispensable qualities, and no one can better appreciate this fact than the sufferer.

LOUISVILLE.

## REPORT ON THE VITAL STATISTICS OF KENTUCKY.\*

BY T. B. GREENLEY, M. D.

It was once advised by some philosopher that when we talked we should have something to say, but on the present occasion I am apprehensive I shall, to some extent, violate that injunction.

At our last meeting I was appointed a

\*Read at the May meeting of Kentucky State Medical Society, Richmond, 1882.

committee to report on the mortuary and vital statistics of the State; but if it was expected that I should base my report on any statistics of that character gathered by the officers of Kentucky within the last decade, the Society will be greatly disappointed.

When I first commenced investigating the matter, I examined the law on the subject in order to learn how and where to find the statistics.

The law is very explicit and positive. It makes it obligatory upon the State Auditor to furnish blanks to the clerk of every county in the State, which he is to distribute among all the physicians and midwives of his county. Said midwives are compelled to keep a register of the births of all children born under their supervision, and the physicians to keep a register of all the births and deaths occurring in their practice, and by the 10th of January furnish a copy of same for the year preceeding to the clerks of their respective counties; said clerks being bound to make a copy of same and forward to the Auditor of State. Said auditor is also directed to furnish blanks to the assessors of the various counties, and it is their duty to make inquiry of every family whether or not a birth or death has occurred in same within the preceeding year.

The assessors are also compelled to make returns of these blanks with their assessment lists to their respective county clerks; copies of which also are to be sent to the auditor, and the original registers of midwives, doctors, and assessors are to be kept in the offices for public inspection.

Now could there be a better law, although somewhat complicated, enacted for collecting the vital statistics of the State than that above alluded to? I think not.

The object of the assessors' work in this particular was to serve as a check to, or means of comparison with, the registers made by the physicians and midwives, and if properly executed afforded very effective means to secure correct returns.

Now, the law on the subject further provides that the State Auditor shall have the statistics thus returned printed and included

in his annual report, and from one to five copies forwarded to the clerk of each county in the State. The clerks were to retain a copy each, to be kept in the office for public examination, and the extra copies to be distributed to persons interested in the matter.

Now, on reading the law on the subject, I thought I had an easy task ahead; that I only had to apply to the clerk of my county for a copy, say of 1887, as it was too early for the report of 1888 to be published. On doing so I found he had but one copy, which of course had to be kept in his office. I next applied to the clerk of Jefferson County, and he had distributed his extra copies. I then applied to the agent of the auditor at Louisville, but he had none. I next went to the Law Library, but none were there. Then I applied to the Polytechnic Library, and found only one copy, 1871. Being a little worried over the matter, I then wrote to the auditor himself for a copy, which he very accommodatingly sent me, but informed me at the same time that the vital statistics were not included in it, stating that they were forwarded every year to our worthy Secretary of the State Board of Health as soon as received for publication. I thought now I had traced the matter up so there would be no further trouble, and wrote to my friend, the secretary, for kindness' sake to forward me a copy of the *last* report. You can not imagine how greatly I was disappointed to receive a very kind letter from him, stating that the board had deemed the returns of so defective a character it had not published them for several years.

Now for a while I was so nonplussed that I did not know what to do; but on reflection I thought it would not do to do nothing and make no report on vital statistics; so I thought of our United States census report of 1880, and fell back on that. But will it be just to appropriate Uncle Sam's work while we remain idle, neglecting duties devolving upon us which are of such importance to our welfare as a State? Under the circumstances we are compelled to resort to this means or have no *report*. Now on whose shoulders does the onus of

the fault lie that we have had no vital statistics of our State for the last several years? Should it be charged to our able and gentlemanly Auditor of State? I should say not altogether; for no doubt the dereliction of duty commenced with his predecessor, the Hon. D. Howard Smith; but he too was a good auditor, and no doubt was not intentionally remiss in the performance of his duties. It may be that our present learned auditor was under the impression that the statistics in question were duly published by the State Board of Health; in fact I am confident that this is his belief, from the letter I received from him on the subject. How the matter was brought about that it became the duty of the State Board of Health to publish them instead of the auditor I can not say, but it is frequently the case that custom takes the place of law. I presume, however, that in this instance the law was allowed to lapse by disinterested desuetude.

There is no other character of statistics pertaining to the welfare of the State neglected in the auditor's report; every thing being fully given in detail and in tabulated form, from the number of pigs and idiots, including the value of the former, as well as the number of dogs, and how much it costs to keep them in the way of tax, up to the number of acres of land and its value. I will venture to say, outside of vital statistics, the late report of our auditor will compare favorably with that of any State in the Union. It shows the rapid strides we are making as a great and prosperous people, the great advances in commerce, agriculture, manufacturing, etc., and I only alluded to the statistics above to show how minute and thorough it was in every particular save the subject under consideration.

But should not the lives and deaths of our people be considered of as much interest as the number of pigs we own or how much corn and hay we raise? The statistics under consideration are essential in order to judge of the growth of our population, the health of our country, and the nature and character of our diseases. If a number of

people wished to form a colony among us, the first thing they would inquire about would be the health of the country; and as we are unable to give them any satisfactory account in that regard, they would naturally look elsewhere. In a great many particulars it is beneficial to keep correct mortuary and vital statistics of a State. We are now regarded as a healthy people, comparing favorably in that particular with most any State in the Union.

If the estimate of the population of Louisville is correct, she stands now, perhaps, as the most healthy city in the United States. In 1880 she stood, in comparison with thirty-one of the largest cities, the tenth in regard to health as far as the white population was concerned. But, owing to her improved sanitary condition since then, her mortuary report per 1,000 is less. It is now about 14.5 per 1,000 of her living white population, and 23.3 per 1,000 of her colored population. This is a great gain in a sanitary point of view over the reports of 1880; the reduction in mortality of the white population being over 6 per 1,000, and that of the colored people of 14 per 1,000. This comparison is made with the United States census report of 1880 by that of the admirable report of Health Officer Galt for the year ending September 1, 1888. He bases his estimate on the hypothesis of 200,000 population, while I take his mortuary list and base the above statement on the estimate of 188,000, as determined by the late city directory, which, perhaps, is very nearly correct.

In speaking of the health and rapid increase of the population of Louisville, I wished to include the birth statistics, and called at the office of the county clerk for that purpose, who had just copied them to be forwarded to the auditor. I was utterly astonished when I examined the birth returns for Louisville and Jefferson County for the year 1888. The entire list amounted to 1,904, and many of these were reported as being born in 1887. For Jefferson County eight births were returned for 1888. I do not know the source of these reports, but

suppose they were made by the assessors. When I examined this report for Louisville and Jefferson County, I exonerated the State Board of Health, and especially my worthy friend, the secretary, of error in judgment in not deeming the vital statistics as returned worthy of publication.

The only possible way by which we can approximate the present mortuary and vital statistics of the State, is to base the calculation on the United States census reports for several decades, and take the ratio of increase or decrease between each decade, and on this ratio base an estimate for the year 1888. I will, therefore, commence as far back as 1850. In that year 30,073 children were born, which was 1 to 32.67 of the population, which was 982,405. In the same year there were 15,033 deaths, being 15.3 per 1,000 or 1.53 per cent of the living population. The ratio of births to deaths that year was 2.13 to 1. In 1860 there were born 38,070 children, or 1 to 30.36 of the population, which was 1,115,684. The deaths that year amounted to 16,467, being 14.7 per 1,000, or 1.42 per cent of the living population. Ratio of births to deaths, 2.76 to 1. In the year 1870 42,020 children were born, or 1 to 31.44 of the population, which was 1,321,000. In that year the mortality was 14,345, being 10.86 per 1,000, or 1.09 per cent of the living. Ratio of births to deaths, 2.90 to 1. In 1880 there were born 52,982 children, or 1 to 31.43 of the population, which was 1,684,600. In the same year the mortality was 23,718, being 14 per 1,000 of living population, or 1.40 per cent. Ratio of births to deaths, 2.24 to 1.

The ratio of males to females born in 1880, was as 2.67 to 2.62, and the deaths as 1.19 to 1.17.

The increase of population from 1850 to 1860 was 18.24 per cent; from 1860 to 1870, 14.31 per cent; and from 1870 to 1880 it ran up to 27.48 per cent. If the same ratio of increase has continued during the last eight years, our population is now 2,245,800. Then, basing the number of births on that ratio of increase, there were born during the year 1888 the number of 71,454

children, or 1 to 31.43 of the population; and, at the same ratio of mortality to population as occurred in 1880, there would have died in 1888 the number of 31,439, being 14 per 1,000 or 1.40 per cent of the population living.

It will be observed, if we compare the birth-rate of 1850 to that of 1860, that there is a decrease of 7.68 per cent, which may be attributed to some extent to the great excitement that year, due to politics and the prospect of civil war. But in the census year of 1870 the birth-rate increased over that of 1860 3.55 per cent, and in 1880 and in 1888 there was but little variation, that of 1870 being 1 to 31.44; that of 1880, 1 to 31.43; and in 1888, 1 to 31.43, all these periods being nearly the same.

When we come to compare the census years as to rate of mortality, we find a greater difference. The death-rate of 1860 was 4.08 per cent less than that of 1850; the year 1870 showed an unusual low death-rate, being only 10.86 per 1,000 of the living population, and, compared with that of 1860, shows a decrease of 35.36 per cent, which is a wonderful difference. But the year of 1870 was unusually healthy over the United States generally. In 1880 the death-rate increased over that of 1870 28.91 per cent, which is less, however, than that of 1860, and the same as 1888, being only 14 per 1,000 of the living population.

The death-rate for Kentucky in 1860, compared with other States, stood in the list as the twenty-eighth; in 1870 the twelfth, and in 1880 the sixteenth, showing a considerable gain as far as diminished mortality is concerned.

The average mortality for the United States in 1880 was 12.54 per 1,000 of the living population.

The mortality of children under one year was 5,754, and that from one to five was 3,907, showing that, of all children who die under five years, 60 per cent die under one year; and that 53.5 per cent of those who die under ten, die under one year, there being 5,369 deaths in 1880 between one year and ten years.

The ratio of deaths under one year to the entire mortality is equivalent to 24.74 per cent. That of the deaths under five years is 41.18, and that of the deaths under ten years is 46.20 per cent; the entire mortality for 1880, as before stated, being 23,718.

There were 70 deaths occurring in 1880 of persons over ninety-five years.

The most prominent causes of death in that year were whooping-cough, diarrhea, dysentery, cholera infantum, scarlet fever, diphtheria, still-births, croup, measles, heart disease, consumption, pneumonia, enteric and malarial fevers.

It will be noticed that in the decade from 1860 to 1870 the increase of our population was only 14.31 per cent; whereas in that from 1870 to 1880 it was 27.84 per cent, being nearly double that of the former period. This great difference is mainly due to the influence of the four years of civil war during that decade, wherein many were killed, and the women were not so prolific on account of the absence of the men.

With the same ratio of increase in 1900 we will have a population of 2,986,000.

Now, returning to the subject of collecting mortuary and vital statistics, what can we say or do? As before remarked, we have laws on the subject amply sufficient for the purpose in every particular. All that is necessary in this regard is to have them enforced. Can it be done?

I believe every physician in the Commonwealth will say, have them enforced. I know that every one who feels pride in his profession, and has at heart the honor and welfare of his State, will be more than glad to have the statistics correctly reported. It is a small matter for each physician to keep a register of his cases of births and deaths, and at the end of the year make a report of them to his county clerk. To be sure, the law prescribes no fee in his behalf, but probably it is taken for granted that as he does so much charity work for his *clientèle* he will not object to do a little for his State.

Then by all means let the law be enforced. We hope every physician and midwife in the State will keep a register of all cases of

births and deaths, and be ready at the end of the year to fill out blanks which I hope they will receive through their respective county clerks. If this is done earnestly and honestly, we will have a report we need not be ashamed to compare with Uncle Sam's census-year statistics.

P. S. Since conferring with Dr. J. N. McCormack, Secretary of the State Board of Health, respecting the present law pertaining to vital statistics of Kentucky, I deem an amendment, as suggested by him, would be preferable to that now extant, which would be more simple and easy of execution. It is as follows: The Secretary of the State Board of Health shall have printed and forwarded to every physician in the State who is legally qualified to practice medicine, and also to every midwife, as far as can be ascertained, blanks, properly formed, by which annual returns of births and deaths may be made, and the same be returned to said secretary, who shall have them printed for distribution among the profession, county clerks, members of the legislature, and officers of State.

For failure of compliance with the law, on the part of either officers or physicians, a proper penalty should be attached.

WEST POINT, KY.

## Societies.

### THE KENTUCKY STATE MEDICAL SOCIETY.

Proceedings of the Thirty-fourth Annual Meeting, held at Richmond, Ky., May 8th, 9th, and 10th, Dr. L. S. McMurtry, of Danville, President, in the chair.

[CONTINUED FROM PAGE 372.]

#### THIRD DAY—FRIDAY, MAY 10TH.

Acute Traumatic Tetanus was the subject of a paper by Dr. R. C. McChord, of Lebanon. He related some cases, and gave the results of treatment. He considered the bromide of potassium the best of all known remedies. (See last issue, p. 356.)

#### DISCUSSION.

Dr. L. H. Clarke, of Lexington, said he had attended several cases of tetanus; none,  
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however, recovered. He believed that all cases are due in some way to traumatism. The treatment by means of the bromides is *par excellence*.

Dr. Ap Morgan Vance reported a case following injury of the thumb. Five days after the injury the patient, in attempting to carry a bucket of water, lacerated the thumb, and soon tetanic symptoms developed. He was given a half dram of the bromide every two or three hours until fully under the influence of the agent. Twice, after he had apparently recovered, the symptoms re-developed, and I had to return to the bromide. He finally recovered.

Dr. J. G. Carpenter, of Stanford, favored stimulating his patients. He kept them drunk on whisky so as to relax the spasms. One ounce of bromide of potassium in twenty-four hours had cured many cases.

Dr. J. G. Brooks, of Paducah, reported a case of traumatic tetanus which occurred in his practice while in the Hawaiian Islands. It was a Chinaman who was about to die, and was a case demanding kill or cure treatment, as the man was suffering terribly and begging to be killed. He gave him five grains of morphine hypodermically. The next morning he was awakened by a crowd of Chinamen who announced to him that the man was much improved. Two years later he was still all right.

Dr. J. A. Larrabee, of Louisville, said he had nine cases, four successful, and all children. He thoroughly believed that any case would yield to bromide of potassium provided the remedy was given in sufficient dose. To the educated physician dosage is simply a botheration. He knows the physiological action, and gives for results. The pathology of the disease is unknown.

Dr. Dudley S. Reynolds, of Louisville, was surprised to hear that any one thought the pathology of traumatic tetanus unknown. It was settled at the Second French Congress of Surgery, which met in Paris in 1886, by Prof. Cornil, who presented the streptococcus as the cause, and his demonstration was so perfect that the Congress

coincided fully with his belief. This great discovery should not be passed over lightly.

Dr. J. M. Mathews: I believe more is to be gleaned out of the successful cases of tetanus reported than by devoting our time to its pathology. He referred to a case of strangulated piles in a condition of gangrene. For several days patient could not open his mouth, which was an evidence of tetanus. Bromide of potassium in sixty-grain doses was given every two hours. Opisthotonos, muscular pains, and all the symptoms of tetanus were on hand. The patient was kept constantly under the influence of the bromide; for seven days he was given sixty grains every two hours, when the dose was diminished. In three or four weeks he was able to return home.

The Transmissibility of Tuberculosis from the Lower Animals to Man was the subject discussed by Dr. John A. Ouchterlony,\* of Louisville, in a learned and elaborate paper. This question was intimately connected with the infectious character of the disease. The power of the bacillus to resist antiseptics is astonishing. Corrosive sublimate does not destroy the bacillus even at the strength of 1-500. The theory of inheritance has been thoroughly shaken by the discovery of the bacillus. Tuberculosis is rarely if ever congenital, but acquired. If the former theory was true, the prospects of eradication would be remote indeed. If the latter is true, this result may be reasonably looked for. We have clinical proof, also, that the disease is contagious. The object of the paper was to show that tuberculosis could be transmitted from the lower animals to man. There can be no security from tuberculosis so long as tubercular meat and milk are used. The disease is contagious, infectious, and not congenital. It is transmissible especially through the alimentary canal and the respiratory tract. Rabbits kept near tuberculous patients contract the disease in twenty-seven days. Rabbits suspended in cages so as to breathe the air exhaled by tuberculous cattle contract tuberculosis. The lungs are the primary seat of

the affection. It may be contracted through the integument, mucous membrane, abraded epidermis, wounded and abraded surfaces. Tuberculosis in dumb animals is identical with tuberculosis in man. Transmissibility to other species is very frequent. The medical profession should inform the public of the condition of affairs and insist on the control of the meat and milk.

#### DISCUSSION.

Dr. J. N. McCormack, of Bowling Green, insisted upon the destruction of the sputum of all tuberculous patients. The State Board has advised that these patients be isolated, and a receptacle for all sputum should contain some destructive agent, or the sputum should be expectorated on paper and burned.

Dr. J. A. Larrabee, of Louisville, hailed with pleasure any agent that assisted in combating this disease, stating, however, that we were very liable to accept too rapidly theories that had not been proved. The lung should be developed to its fullest extent by means of gymnastics, or by other exercise. The shallowness of the respiration invites the progress of this disease more than any thing else I know of.

Speeches warmly commending the ideas presented in this paper were also made by Drs. Reynolds and Carpenter, and on motion a committee, consisting of Drs. J. N. McCormack, Bowling Green, Dudley S. Reynolds, Louisville, John A. Ouchterlony, Louisville, and Wm. Bailey, Louisville, was appointed to bring this subject before the public.

The Peculiar Systems of Medicine,\* by Hardin H. Bright, A. M., M. D., of Richmond, was read by title.

The Pathogenesis of Hysteria, by John F. Barbour, M. D., of Louisville, was read by title.\*

The Report on the Vital Statistics of Kentucky was read by T. B. Greenley, M. D., of West Point. (See p. 389.)

The Report on Otology was made by Dr. J. M. Ray, of Louisville. (See last issue,

\* The full text of this paper will appear in the next issue.

\* Will appear in an early issue of the American Practitioner and News.

p. 361.) He said that medical men were now giving more time and attention to ear diseases than formerly. Many still treat the ear without giving the nose and throat especial study. The deaths of two prominent men recently from diseases of the ear have called attention to these troubles.

Dr. J. G. Carpenter, of Stanford, held that aseptic and antiseptic measures of the treatment were the *sine qua non* in all troubles of the middle ear.

The Management of Incised Wounds was the subject of a paper by Dr. C. Skinner, of Louisville. He favors irrigation. (See this issue, p. 387.)

Dr. T. Hunt Stuckey, of Louisville, thought that in some cases (circumcision, for instance) irrigation favored edema. He would prefer the dry dressing in such a case.

Rupture of Tendon of the Quadriceps Extensor with Displacement of the Patella Downward and Outward was the subject of a paper by T. B. Greenley, M. D., of West Point. "On the 5th of December, 1889, at night, I was called to see Mr. R., a farmer, aged forty years. About dusk he was feeding his horses, and as he passed one of them received a kick on the inside and slightly above the knee-joint of the right leg, the onus of the blow falling on the inside and upper border of the patella.

"I saw him about two hours after the accident, and found the patella on the outside and slightly below the joint, lying comparatively loose under the skin, with its upper border looking posteriorly. There was great tumefaction at the site of the blow and in front of knee-joint. Owing to this great swelling I was unable to place the patella in its proper position. I bandaged the limb above the knee, requesting the patient to keep as quiet as possible, and in two days I thought I would be able to replace the organ.

"December 7th. Swelling of the joint considerably reduced, and I was able to effect reduction of patella. I then applied adhesive strips so as to secure the organ in its position, and so bandaged his leg as to prevent flexion. The adhesive strips met two

indications, first, to confine the patella in its place, and secondly, by gentle pressure to promote absorption of the effused fluid around the joint. With instructions to my patient to keep the joint as much at rest as possible, stating to him the gravity of the accident, I left him with the understanding that as soon as the swelling was sufficiently reduced I would apply a permanent dressing and allow him to go on crutches, so that he could to some extent superintend his business affairs.

"December 20th. Applied a permanent bandage, the swelling having measurably disappeared. He was now allowed to go on crutches, which he did for over two months, when the bandage was removed. He was now directed to bear some weight on that limb, and to gradually use the knee-joint by gentle flexion and extension. While the limb was extended he could bear his weight on it, but if flexed beyond a very obtuse angle he could bear but very little weight.

"I examined the condition of the knee ten days ago, and found no difference in the appearance of the two joints. He walks now without any artificial support, without limping, and can bear his weight on the limb when flexed to an angle of 135 degrees. The only difference he notices in the use of the two limbs is that there is some soreness above the knee of the right leg upon pressure, and that if he bends the leg too far back it is inclined to give way.

*Remarks.*—In examining authors on the subject of dislocation of the patella, I find no mention of displacement downward. I have, however, only consulted Erichsen, Joseph and Thomas Bryant, Ferguson, and S. D. Gross. The first four do not speak of such an accident, and the last, Dr. Gross, only mentions it to say there is no record of such displacement, and remarks that in his estimation it could not occur.

"When we examine the manner in which the tendon of the extensor quadriceps cruris encircles the base of the patella, and extending down its margins some distance, one would naturally be impressed with the

same opinion as the great surgeon. But, nevertheless, sometimes things occur which "in our philosophy we never dreamed of" and are unable to satisfactorily account for, and on the present occasion I cite this as one of the phenomena which may seem inexplicable.

"I have only met with one case of dislocation of the patella before. It was simple, being produced by violence, and was thrown on the outside of the joint on the external condyle of the femur. Under chloroform it was reduced by extension and counter extension of the limb.

"It may be thought by some that in reporting the present case of rupture of the tendon of the quadriceps extensor and dislocation of the patella downward, I am mistaken as to its true character. But on this point I can not be, and at the time, being surprised myself, I called the attention of the patient to the fact, who was the only witness beside myself except a negro man who assisted me in dressing the limb."

The Report on Medical Ethics was made by Dr. Dudley S. Reynolds, of Louisville. He spoke in substance as follows: Before attempting to consider whether a written code of ethics is necessary to the medical fraternity, it might be well to separate it from law. Ethics is the voluntary moral principle of educated people, societies, or associations of men.

In order to create a common ground for the organization of the whole medical profession of the United States, a series of ethical principles were formulated, and the profession invited to adopt these as a basis or platform. That code provides for the recognition of such persons as have the proper educational training, and who may be willing to subscribe to the moral principles embodied in the code. This has brought every legitimate specialty in medical research and practice into fraternal relations with the general practitioner and to each other. In that sense it is like the Constitution of the United States, affording a plan upon which State and local associations are formed, and through an assembling of dele-

gates from all these a national body has been organized. One often hears that "gentlemen need no written code of ethics." This is true as to the merely personal deportment of those whose natural refinement and educational training entitle them to the rank of gentility, but it does not suffice for the establishment of a common principle clear enough to form the basis of an organization.

The Code of Ethics of the American Medical Association is the fundamental principle upon which the regular medical profession of the United States is organized. Every civilized country has a national association, and every one of these has its written code of ethics. Thomas Percival is the author of the British code, and that furnished the principal material for our own code. There has been a great deal of animadversion on the subject of medical ethics, and a great deal of bitterness exhibited by some local societies in attempting to make odious to the general public those who have violated the code. The only recognized penalty for a violation of the ethical principles of any church organization, political party, or medical society, is ostracism by the members of the body. If I violate the Code of Ethics of the American Medical Association, the local society to which I belong must induce me to cease that violation or expel me.

If not, my local society can no longer be recognized in the State Society, nor send delegates to the National Association. In adopting a code of ethics we exercise no power over the personal freedom nor the property of any one. We simply say what one must agree to do in order to sit with us in our meetings. It is plainly necessary, therefore, that we shall have a national code of ethics, and that we should all observe its provisions in the organization of our local societies, that we may be a united profession.

Dr. Larrabee, of Louisville, had never heard that hydra-headed monster, medical ethics, made so beautiful as Dr. Reynolds made it. He considered ethics the conduct of gentlemen. If a man is a gentleman, he will need no ethics; if not a gentleman, ethics will not make him one.

Dr. E. M. Duncan, Chairman of the Committee on Necrology, made the following report:

John Lewis Price, M. D., was born at Nicholasville, Ky., April 20, 1835, and received his early education at the high school in Mt. Sterling, going thence to Independence, Mo., to begin the study of medicine under the guidance of Dr. John L. Price, of that place.

His first course of lectures was taken at the old McDowell College in St. Louis, which was a famous institute in its day, and in 1860 he graduated from the Medical Department of the University of Louisville.

Going at once to Mercer County, he began the practice of his profession with an earnestness and devotion that at once insured success. From Mercer he removed to Clark County, and from Clark County to the city of Lexington, where he soon took rank with the foremost in his profession.

With the highest convictions of duty, a genial and kindly nature, full of charitable impulses, he was at once a useful citizen and a public benefactor, and in his death, which occurred at Lexington, Ky., from phthisis pulmonum, Saturday morning, January 5, 1889, the public and his profession sustained a serious loss. This Society now mourns the loss of a loved, intelligent, and honored member.

Besides being a member of this Society, Dr. Price was also, at the time of his death, a member of the Mercer County Medical Society, the Central Kentucky Medical Association, and the American Medical Association.

Dr. John G. Davis, chief surgeon of the L. N. A. & C. Ry Co., being present, was invited to a seat on the platform and requested to participate in the deliberations. Dr. Davis expressed his thanks for the honor conferred, and indulged the hope that fraternal relations might be established between the Association of American Railway Surgeons and other legitimately organized bodies of the medical profession. He did not appear in his official capacity to represent a railway company, but as the representative of an

organized body of professional gentlemen whose duties called them at all sorts of unseasonable hours to perform the most delicate and difficult surgical operations for the relief of our fellow creatures who were the unfortunate victims of accident. He felt it a matter of some importance that the medical profession everywhere should recognize the necessity for co-operation in attempts to advance the proficiency of the medical service of railway companies. This department of the public service was just beginning to undergo some degree of systematic development. That it might do so in the most rapid and scientific manner, the railway surgeons of the United States had organized themselves into an association for the discussion of such subjects as properly belong to that branch of the practice; and we must all admit that it has some especially peculiar features. With best wishes for a successful meeting and thanks for courtesies extended, Dr. Davis took his seat.

Ex-Governor James B. McCreary was present and made a speech in which he extolled the medical profession very highly. He had served with them in the pursuits of peace and of war, in the legislative halls of the State and nation, had yielded his place in the gubernatorial chair to a doctor, and one of this profession from his own city of Richmond now occupied the office of the Chief Justice of the United States.

The national formulary was, on motion, indorsed. A committee, consisting of Drs. J. G. Carpenter, of Stanford, Steele Bailey, of Stanford, and H. Hart, of Lexington, was appointed to attend the meeting of the Pharmaceutical Association at Crab Orchard, May 15th.

Officers elected were as follows: *President*, John A. Ouchterlony, Louisville; *Vice-President*, Wm. Jennings, Richmond; *Second Vice-President*, R. A. Wills, Lexington; *Permanent Secretary*, Steele Bailey, Stanford; *Assistant Secretary*, John Y. Brown, Henderson; *Treasurer*, J. B. Kinnard, Lancaster. Henderson was chosen as the next place of meeting and J. S. Lusk as chairman of the Committee of Arrangements.

On the first evening of the session an elegant hop was given at the rooms of the Madison Club, and a banquet was served at the Garnett House on the evening of the second day. The master of ceremonies was Dr. Jennings, of Richmond. Toasts were responded to as follows: Our Guests, Ex-Governor McCreary, of Richmond; Medical Education, Dr. Dudley S. Reynolds, of Louisville; The Young Doctor, Dr. J. M. Mathews, Louisville; The American Doctor, Dr. W. H. Wathen, Louisville; The Kentucky Doctor, Dr. L. S. McMurtry, Danville; The Absent Ladies, Dr. O. D. Todd, Eminence. The banquet was a success.

The Society adjourned.

### Reviews and Bibliography.

**Atlas of Skin and Venereal Diseases**, comprising original Illustrations and Selections from the plates of Kaposi, Hutchinson, Neumann, Fournier, Ricord, and others, with original text. By PRINCE A. MORROW, A. M., M. D., Clinical Professor of Venereal Diseases, formerly Clinical Lecturer on Dermatology in the University of the City of New York. Fasciculi, x, xi, xii, xiii, xiv, xv. New York: William Wood & Co. 1889.

The plan, scope, and technical merits of this superb work were made known to our readers on the appearance of the earlier numbers. Those were devoted to the lesions of syphilis. The fasciculi under notice discuss in text and set forth in pictorial illustration non-syphilitic skin diseases.

Fasciculus x treats of Eczema of Palm, Psoriasis of Palm; Eczema rubrum, Eczema seborrhoicum; Impetigo figurata, Impetigo contagiosa; Dermatitis exfoliativa, Pityriasis rubra; Dermatitis medicamentosa.

Fasciculus xi: Herpes zoster, Herpes febrilis, Herpes progenitalis; Dermatitis herpetiformis; Pemphigus vulgaris, Pemphigus follicaceus; Purpura simplex, Purpura thrombotica.

Fasciculus xii: Psoriasis; Lichen planus, Lichen ruba, Lichen ruber moniliformis; Acne vulgaris, Acne rosacea; Molluscum epitheliale, Verruca senilis.

Fasciculus xiii: Elephantiasis of leg and

scrotum; Leucoderma; Alopecia areata; Ke-  
loid; Fibroma; Xanthelasma; Rhinoscleroma;  
Xeroderma pigmentosum.

Fasciculus xiv: Lupus erythematosus, Lupus vulgaris, Lupus papillaris; Tuberculosis papillomatosa cutis; Sarcoma of the trunk, Sarcoma of face; Epithelioma; Rodent ulcer; Leprosy.

Fasciculus xv: Scabies; Pediculosis corporis; Chromophytosis; Tricophytosis and favus; Eczema marginatum favus.

Each of these affections is admirably described in the author's clear style, and illustrated by perfect chromo-lithographic plates. As the work progresses it is clear that the promise of of the publisher's prospectus will be fulfilled to every jot and tittle, and equally clear that one need not go abroad to familiarize himself with this department of medicine.

On the Animal Alkaloids, the Ptomaines, Leucomaines, and Extractives as to the Origin of some Diseases by or through the Physiological Process going on During Life. By Sir William Aitken, Knt., M. D., F. R. S., Professor of Pathology in the Army Medical School. 16mo, pp. 61; cloth, \$1.00. Philadelphia: P. Blakiston, Son & Co. 1887.

### Correspondence.

#### LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

The report of Mr. Erichsen, inspector, showing the number of experiments performed on living animals during the year 1888, under licenses granted under the Act of 1876, has been laid on the table of the House of Commons. It appears that the total number of experiments reported as having been performed during the year by the fifty-five licensees was 1,069, being a decrease of 151, as compared with the total of 1887. In concluding his report Mr. Erichsen, after observing that the main object of the act was to secure immunity from suffering to animals subjected to experiments for scientific purposes by the imposition of certain restrictions on all experiments calcu-

lated to give pain, states: "My attention, as one of those who are responsible for carrying out the provisions of the act, has been specially directed to this humane object. It is a matter of very great satisfaction to find, by the reports furnished to me this year, that the cases in which pain has unavoidably been inflicted were far fewer in number than in preceding years. Only eight experiments were reported as having been attended by pain, the animals in these cases being rabbits, guinea-pigs, mice, and frogs. In the attainment of this gratifying result, every assistance has been afforded by the licensees, who, I have reason to believe, spare no trouble, by the use of anesthetics, often applied locally in addition to their internal administration, and by the employment of strict antiseptic precautions to secure freedom from suffering in the animals experimented upon."

Picrotoxine is being recommended as an antidote for morphine, on the ground that it exerts an antagonistic action to the latter alkaloid on the respiratory centers, for, while morphine tends to paralyze these centers, picrotoxine exerts a powerfully stimulating effect upon them. Since, therefore, death in morphine poisoning is usually attributable to paralysis of the respiratory center, on this ground alone should picrotoxine be indicated as a valuable antidote. Besides this, morphine may produce such rapid reduction in blood pressure as to endanger life, while picrotoxine, on the other hand, is a powerful stimulant to the vasomotor center, and is in this respect also antagonistic to morphine. The action of morphine on the brain appears to be directly opposed to that exerted by picrotoxine, and hence it is suggested that the previous administration of a small dose of the latter alkaloid might reduce the danger of asphyxia in chloroform narcosis.

A well known medical man, who has recently been in Norway, gives a glowing description of their manner of treating dipsomaniacs. An habitual drunkard in Sweden and Norway is treated as a criminal in this sense, that his inordinate love of strong

drink renders him liable to imprisonment, and while in confinement it appears he is cured of his bad propensities on a plan that, though simple enough, is said to produce marvelous effects. From the day the confirmed drunkard is incarcerated no other nourishment is served to him or her but bread and wine. The bread, however, it should be said, can not be eaten apart from the wine, but is steeped in a bowl of it and and left to soak thus an hour or more before the meal is served to the delinquent. The first day the habitual toper takes his food in this shape without the slightest repugnance; the second day he finds it less agreeable to his palate, and very quickly he evinces a positive aversion from it. Generally, the doctor states, eight or ten days of this regimen is more than sufficient to make a man loathe the very sight of wine, and even refuse the prison dish set before him. This manner of curing drunken habits is said to succeed almost without exception, and men or women who have undergone the treatment not only rarely return to their evil ways, but from sheer disgust they frequently become total abstainers afterward.

At the last meeting of the Pathological Society of London, Mr. I. Hutchinson, jr., described an interesting specimen of osteoma of a metacarpal bone. The tumor was a smooth oval one, with a broad attachment to the shaft of the index metacarpal bone on its outer side. It was the size of a small hen's egg, and had pushed out ward and greatly flattened the adjacent middle metacarpal bone. It filled the interosseous space and projected into the dorsum of the hand. It was obtained from an elderly man, and had existed many years. During life the tumor had been supposed to consist of excessive callus following a fracture in earlier years. On cutting the tumor across it was seen to be a cancerous osteoma, in the center of which, surrounded by soft granulation tissue, was a small piece of bone of a different color from the rest, more granular, and apparently partially necrosed. There was no trace of suppuration having

existed at any time, but it seemed probable that the irritation of the partly dead bone had led to the production of the osteoma.

At the last conferment of degrees at the London University, a unique ceremony took place in the presenting of the M. D. degree to Mrs. Scharlieb, the first woman to receive the London diploma of Doctor of Medicine. Mrs. Scharlieb took the London M. D. & B. of Surgery in 1883, and went to Madras to work among the natives. Thence she returned two years ago, and now holds the appointments of physician to the out-patients of the New Hospital for Women, Marylebone road (the foundation stone of which was laid by the Princess of Wales the other day), Joint Lecturer on Forensic Medicine to the London School of Medicine for Women, and Queen's Lecturer to the National Association of Nurses.

Dr. Matthew Hay, Medical Officer of Health for Aberdeen, has traced the history of a recent case of smallpox in Aberdeen. The patient was a young stone-cutter. His sister was a worker in a flax and jute mill, and contracted a mild form of the disease through handling raw flax and jute imported from Russia. The disease she communicated to her brother, who was seriously affected. Dr. Hay states that though imported rags have often been the cause of smallpox, this is the first case in which, so far as is known, the disease has been caused by raw goods.

His Royal Highness the Prince of Wales, accompanied by Prince Albert Victor and Prince George of Wales, visited the Medical Examination Hall, Victoria Embankment, and unveiled a statue to the Queen, erected by the Colleges of Physicians and Surgeons in honor of Her Majesty's Jubilee. The Prince observed that "in no building is there a better statue of the Queen." The seventieth birthday of Her Majesty was very appropriately chosen for the ceremony.

The College of Surgeons is bestirring itself about the Lunacy Acts Amendment Bill. Mr. John Marshall and Mr. Sibley, together with the president and vice-presi-

dents, have been appointed a committee to consider and report.

The young lady who took first place in senior practical anatomy at the recent examination, Royal College of Surgeons, Dublin, is Miss Emily Dickson, second daughter of Mr. Thomas A. Dickson, M. P., Stephen's Green, Dublin.

Mr. George Holmes, of Sheffield, has under his will bequeathed about £13,000 to the three infirmaries of Sheffield, Manchester, and Liverpool.

LONDON, May, 1889.

## Abstracts and Selections.

**THE ARREST OF PHTHISIS.**—The Islington Medical Society met on March 26th to hear an address from Dr. Sansom on the Arrest of Phthisis and the way in which it occurs. Dr. Sansom was disposed to think that the bacillus of tubercle had a tendency to die out like other germs, if it could be put into unfavorable circumstances. Analyzing about twenty cases, in which from careful personal observation he was satisfied of the arrest of phthisis, he found that the most invariable condition to be noticed was that they all had climatic change, not in any given place or climate, but somewhere out of the air of crowds and towns. He attached more importance to this element in treatment than to any merely medicinal measures. Of these cod-liver oil was best, sometimes administered by the rectum when it was not acceptable to the stomach; and he recommended the inunction of carbolic acid over the apices in the form of an oil, one part of carbolic acid to four of olive oil. He did not find that preparations of iron had been used in these successful cases. A member directed attention to the remarkable exemption from phthisis of the Faroe islanders, who lived in a very moist air, and fed largely on fish and wind-dried mutton. They had plenty of bronchitis and rheumatism, but no phthisis. The account of these islanders and their sanitary condition is to be found in the British and Foreign Medico-Chirurgical Review, vols. vii, and xi. It may be hoped that Dr. Sansom is a little too absolute in thinking change of air and climate essential to the occurrence of spontaneous cure or arrest of phthisis. It would be a bad lookout for our poorer patients if the chance of cure depended on the, to them, entirely

impracticable remedy of a change of climate. The fact seems to be that the tendency to tubercle seems to be much more common than is thought, as well as the tendency to get over it. Dr. Herberden, in his Commentaries, shows that he had knowledge of such processes, and gives one or two cases in point. Our best knowledge of the chances of the arrest of phthisis is based on observations in the pathological theaters of the great hospitals of large cities, Edinburgh, Paris, London, and Vienna. It was these that gave Hughes Bennett, Williams, Rogée, Boudet, and others their first belief in such a process. We can not do better than reproduce here the words of Dr. Bennett: "The careful dissections of morbid anatomists have recently shown that this arrestment (of the further deposition of tubercle), instead of being a rare or occasional occurrence, really happens with extreme frequency. In 1845 I made a series of observations with reference the cretaceous masses and puckerings so frequently observed at the apices of the lungs in persons advanced in life. The conclusion arrived at was that the spontaneous arrestment of tubercle in its early stage occurred in the proportion of from one third to one half of all the individuals who die after the age of forty. The observations of Rogée and Boudet, made at the Salpêtrière and Bicêtre hospitals in Paris among individuals generally above the age of seventy, showed the proportion in such persons to be respectively one half and four fifths." The observations of Heitler in the *post-mortem* room of Vienna are to the same effect, and show a large proportion of spontaneous recoveries.—*London Lancet*.

IS SYPHILIS INCURABLE?—There must be many practitioners who have had opportunities of seeing cases of syphilis, have watched them for years, which have given indications of what may be called a termination in cure. Syphilis may be considered a very prolonged fever, marked by certain symptoms and stages, more or less definite, and continued frequently through many years; in fact, of a very indefinite duration, but in many instances followed by such a recovery as may fairly be deemed a cure. In its course it produces certain influences on the economy, modifying the nutrition and development of certain parts, which effect is probably permanent, in the sense that it has undergone such a process. But if this is so, we must admit the same of several other complaints usually considered curable, especially of that group of diseases

to which our childhood is particularly exposed—measles, scarlet fever, *et passim*. Probably, and more than probably, each of these in its course produces certain modifications and changes in the economy, has certain symptoms and stages more or less marked, though of comparatively limited duration, with the result that the individual is not exactly what he was before; but it is not customary to call such complaints incurable, but, as in syphilis, there is and must be an essential difference in the individual to one who has not been affected by such a virus. Are we then to extend the number of our incurables? Are we to inform our patients they are suffering from incurable diseases when attacked by exanthemata? This will, indeed, be a heavy burden for our art to bear. At the same time, I wish to guard myself from treating the question too lightly. I believe syphilis to be a most serious complaint, possibly the most serious, and curable only by the most careful application of remedies, by patience and self-control, and a prolonged attention to hygienic and curative measures. The following case may interest:

About twenty-four years ago I attended a gentleman who had a primary sore, followed by a sore throat and a squamous rash. He was treated by a prolonged mercurial course, potas. iodidi, etc., and in time all the symptoms disappeared. I advised, after all evidence seemed gone, to wait two years before contemplating marriage. Between four and five years after his initial symptom he married. His wife is living and well now. She has had nine children and no miscarriages; the children have never shown any mark or symptom referable to the disease. The patient himself is still alive, in fair health only, because of late years he has indulged in alcohol; still he gives no evidence of his original malady.

It is this is not a cure, it is *very like one*, and as satisfactory as one can be. If, however, this is an incurable case, where are we to find a recovery from any of our infantile febrile disorders? I specify these particularly, because nearly every one like to go through them. Are we then all incurables? *Dr. J. Roche Lynch, British Medical Journal*.

HOW DOES SUSPENSION ACT IN LUMBERMAN AFRAXY?—It has been ascertained that in talis posterior spinal meningitis latently accompanies the pathological changes in the nerve tubes of the posterior columns. The pia mater is found compressed and thickened at the level of the posterior columns, the spinal

fluid being unduly increased, and this change being more pronounced in the dorso-lumbar than in the cervical region of the cord. Now I maintain that the good effects which are sometimes obtained by cauterization of the spine in such cases are rather owing to its revulsive influence on the meningitic process than on the sclerosis of the nerve tubes; and it appears to me highly probable that part of the influence of suspension, by which the spinal cord is efficiently stretched, is owing to the *breaking down of adhesions from chronic meningitis*, thus allowing a freer transmission of nervous influence along the nerve tubes, more especially those which run on the surface of the posterior column. This explanation appears to me also to account for the fact that suspension acts better in advanced than in fresh cases of locomotor ataxy. In recent cases there is more tendency to inflammatory irritation, which may be made worse by stretching, just as recent cases of disease of the joints, tendons, ligaments, etc., are improved by rest, and old cases by forcible extension.

2. The morbid process in the posterior columns and nerve roots consists essentially of destruction of the medullary sheath and the axis cylinder of the central nerve tubes, together with overgrowth of the interstitial connective tissue or neuroglia which cements the nerve fibers. The neuroglia, from being originally soft and yielding, gradually, as the disease progresses, loses its cells and nuclei, becomes firm, hard, and fibrous, and is liable to cicatricial shrinking. The gradual contraction of this tissue causes compression and squeezing of the central nerve tubes, and thus serves to impair their nutrition and conductivity. Now it seems to me allowable to assume that, by the process of stretching the spinal cord, *the overgrown and unduly hardened neuroglia may be loosened and broken down*, with the effect that those nerve tubes which have to some extent survived the sclerotic process are freed from compression, become better nourished, and may thus be enabled to transmit the nervous influence more efficiently than before. Apart from this, however, I have come to the conclusion that suspension has, in a number of cases, a beneficial influence on the medulla oblongata, as it stimulates the centers for vaso-motor and cardiac action and for digestion. In several patients whom I have submitted to this treatment, I have noticed that the pulse, which was unduly quick and of low tension before they were suspended, fell by six or eight beats and acquired more tension after they had been taken down. In a majority of my cases the appetite and digestion have improved, and mental depression has been lessened or removed.

The forms of nervous disease for which my personal experience leads me to think that suspension is applicable are the following: (1) Locomotor ataxy in the second stage. (2) Paralysis agitans. (3) Spastic spinal paralysis. (4) Amyotrophic lateral sclerosis. (5) Functional nerve prostration, more especially where there is feeble action of the heart, loss of appetite, and severe mental depression.—*Julius Althaus, M. D., London Lancet.*

#### THE SLOW PULSE AND ITS PATHOGENY.—

At the Paris Therapeutical Society, on March 27th (*Progr. Méd.*), M. Huchard read a paper upon Slow Pulse Associated with Syncopal and Epileptiform Attacks and its Treatment, proposing to term the condition Stokes-Adams' disease, from the names of those who first pointed it out (1836). Those authors attributed the symptoms to fatty degeneration of the heart. Charcot and Blondeau considered them due to a bulbar lesion (from cases ensuing on lesion of the spinal column) and to medullary disturbance. M. Huchard would add to these factors the influence of renal disease, and particularly of arterio-sclerosis. In cases recorded by Débove, and some observed by himself, he has seen the phenomena of slow pulse with syncopal and epileptiform attacks complicated with true angina, and later with edema and albuminuria. One of the cases showed a transition of symptoms from those of bulbar origin to cardiac and finally to renal. The treatment proposed—obviously only palliative—consists of iodide of potassium or sodium, combined with nitro-glycerine, or subcutaneous injection of nitro-glycerine alone. Afterward, as arterial tension lessens, he gives caffeine hypodermically, and, should uremic symptoms occur, places the patient on a milk diet. In a discussion on the paper, M. Fernet objected to give a name to the "syndrome," and pointed out the inconveniences attending the use of proper names in nosology. Moreover, Adams and Stokes did not correctly ascertain the pathogeny of the affection, which might more reasonably be named after Hutchinson. Nor could M. Fernet concur in referring all cases to arterio-sclerosis, since instances of slowness of pulse with syncopal and epileptiform attacks are met with in injuries to the medullary region, in cervical pachymeningitis, in diphtheritic bulbar paralysis, etc. M. C. Paul pointed out that in their later stages the cardiac class of cases resembled the renal, so that it was often difficult to determine the part played by uremia in such cases. M. Huchard, in reply, said he did not insist on the name he had proposed, and that he had not confounded the cases he described with those referable to diverse lesions of the medulla.

In reference to this it may be remarked that in his chapter on Fatty Degeneration of the Heart ("Diseases of Heart and Aorta," 1854) Dr. Stokes quotes a case of Dr. Cheyene's, as well as that of Dr. Adams, and indicates "cerebral symptoms" as being commonly present in this form of cardiac disease. These symptoms, he adds, "consist in the occurrence of repeated pseudo-apoplectic attacks of various degrees of intensity and duration. They are seldom followed by paralysis. Attacks of vertigo, dimness of vision, and syncope are observed."—*Ibid.*

**SIMPLE METHOD OF TREATING CORYZA.**—Camphor in various forms is frequently recommended for colds in the head, although Dr. George Johnson and others long since indicated the dangers attending the use of concentrated alcoholic solutions. The following method of application is suggested in a Swiss pharmaceutical journal, and certainly has the merit of simplicity: A jug is half filled with boiling water, into which a teaspoonful of well-powdered camphor is thrown. A funnel-shaped paper cap is then placed on top of the jug, and a hole torn in it just fitting the nose. The camphorated steam is inhaled through the nose for ten or fifteen minutes, the inhalation being repeated, if required, every four or five hours. If the patient resolutely persists with the inhalation, in spite of its unpleasantness, it is said that three repetitions will always effect a cure, however severe the coryza may be.—*Ibid.*

**ACUTE PANCREATITIS.**—The Middleton-Goldsmith lecture recently delivered before the New York Pathological Society by Dr. Reginald H. Fitz, Shattuck Professor of Pathology in Harvard University, dealt with the acute diseases of organs, to which the pathologist as a rule pays but little attention; neither the symptoms nor the morbid anatomy of diseases of the pancreas are well understood, unless we may except malignant disease. Dr. Fitz has collected a series of cases of acute disease of the pancreas, the majority of these are examples of acute pancreatitis, but a few are instances of hemorrhage into the pancreas. The symptoms of pancreatic hemorrhage are not very characteristic, sudden collapse, which may or may not be preceded and accompanied by severe abdominal pain, death may occur within half an hour. After death hemorrhage, which may be diffused or circumscribed and multiple, is found in the pancreas, in the subperitoneal tissue around it, and in the omentum, the mesentery, and the perinephritic fat tissue. The rapidly with

which the blood, it must be assumed, is poured out suggests the probability that it comes from a ruptured aneurism, but no aneurism has been found in any of the cases. Dr. Fitz classified cases of acute pancreatitis under three heads—hemorrhagic, suppurative, and gangrenous—and he believes that inflammation of the pancreas is far more common than is generally thought, since it commonly originates, in his opinion, by the extension of inflammation from the duodenum along the pancreatic duct, he considers that the recognition of this occasional complication of a relatively simple affection is important. Associated with the pancreatic disease it is usual to find in the subperitoneal tissue of the abdominal wall, mesentery, omentum, and pancreas, and in the substance of that gland, scattered areas of fat-necrosis varying in size from a pin's head to a hen's egg. These nodules are produced by an inflammatory process, probably of an infective nature and secondary to the pancreatitis. Suppurative pancreatitis may be acute, but is more usually subacute, with a marked tendency to become chronic. The pus may find its way into the stomach, or duodenum, or into the cavity of the great omentum; hemorrhagic pancreatitis generally leads to death in from two to four days. It may lead to the death of the whole gland—gangrenous pancreatitis—and if the patient survives the acute symptoms at the onset, recovery may eventually take place, the pancreas becoming in time completely detached by suppuration from all its attachments and lying free in an abscess cavity, which may in the end open into the intestine, and the gland be passed *per anum*; gangrenous pancreatitis may also be produced by perforating ulceration of the gastrointestinal or biliary tracts. The common symptoms of acute pancreatitis are sudden, severe, often intense epigastric pain, without obvious cause, in most cases followed by nausea, vomiting, sensitiveness, and tympanitic swelling of the epigastrium. There is prostration, often extreme, frequent collapse, low fever, and a feeble pulse. Obstinate constipation for several days is the rule, but diarrhoea sometimes occurs. The diagnosis, therefore, is based on pain, tenderness, and tympany limited to the region of the pancreas, and on the gradual development of a deep-seated peritonitis in the same place. The disease is most liable to be confounded with typhoid presenting perforation of the intestine or bile ducts, and acute intestinal obstruction. From the first named it may be distinguished by the history and an examination of the

vomit. Perforating ulcer of the stomach or duodenum is to be excluded by the absence of pain after eating, hemorrhages from the digestive canal, and cachexia. Acute perforation of the transverse colon is rare, and gives rise to a more rapid and extensive peritonitis; in perforation from gall-stones there is generally a history of biliary colic. From acute intestinal obstruction the diagnosis is very difficult. Dr. Fitz thinks that it may be made by establishing, through injection, the patency and capacity of the large intestine, by the rarity in the epigastrium of an obstructed small intestine, by the immediate presence of localized tenderness, and by the usual absence of conspicuous general tympany or limited distension of intestinal coils. *British Medical Journal.*

CAN PNEUMONIA BE CUT SHORT BY ANTI-PYRIN?—Most people, I should say, are skeptical as to the power of any drug cutting short such a disease as pneumonia, the question naturally arising when such a subject is broached being much the same as suggests itself when "cures for cancer" are mentioned. Was it the disease at all?—and the conviction of the reality of the disease those who have seen it will always have great difficulty in imparting to those who have not; still, I think the following history ought to be almost conclusive.

The patient, aged twenty-one, has had two previous attacks of pneumonia: the first one four years ago; the second last winter, a very severe attack, in which I attended him. On February 25th he went to his work at 5 A. M. feeling perfectly well; at 6 A. M. he commenced to shiver, was then sick, and felt so ill that it was with difficulty he reached home. He then went to bed. At 3 P. M. pain in the left chest and cough came on, and he expectorated some rusty sputa. I saw the patient at 5:30 P. M.; he had then constant short cough, complained of pain in the side, and felt very ill. Temperature, 102.6°; respiration, 24; pulse, 120. On examining his chest, resonance was good in front, with ronchus under the left nipple. Behind, over the left side, the resonance was high pitched, and from the angle of the scapula downward there were well-marked fine crepitations. He was ordered fifteen grains of antipyrin at once, and poultices. Next day he told me that after the powder he slept well. The cough and pain became much less troublesome; he still had both, but felt much better. Temperature, 98.4°; respiration, 18; pulse, 70. The condition of the lung was the same as on the previous evening.

On February 27th he was much better, and slept well all night. He coughed very little, and had scarcely any pain when he did so. The resonance was the same on both sides of the chest. On taking deep inspiration, crepitations could still be heard over the same area, and loud ronchus under the angle of the scapula. Temperature normal. On the 28th he was quite well.

Was this a case of pneumonia? Does true pneumonia ever abort without treatment? These questions I leave others to decide, my own feeling upon the matter being that the next time I am called to a pneumonia sufficiently early I shall once more try antipyrin. *Dr. H. Counsell, London Lancet.*

WOUNDING WITH POISONED ARROW.—Mr. Joseph White described (Nottingham Medico-Chirurgical Society) the case of a servant girl aged twenty-three, who, while standing on a "pair of steps" dusting some shields, etc., on the wall of the hall, fell to the ground, and in her fall had her right arm pierced by the point of an Indian arrow, which was arranged point upward in a stand below. The arrow was withdrawn in two minutes, and the patient was seen within half an hour of the time of the accident. When seen the patient was in a state of collapse, with slow, shallow, jerking respiration and very feeble circulation. As the wound was throughout its track covered with brown (apparently vegetable) substance, it and the surrounding tissues were immediately freely excised and stimulants administered. The breathing becoming rapidly more slow and feeble, and then ceasing, an interrupted galvanic current was passed through the diaphragm, and artificial respiration kept up for more than an hour, during which time the heart acted extremely feebly. In two hours from the occurrence of the accident, and when artificial respiration had been maintained for about an hour and a half, respiration gradually returned and the pulse improved, and in a short time the patient was able to take small quantities of fluid nourishment, and during the day she gradually revived. For three or four days the girl remained in a very feeble condition. She was drowsy and disinclined for any mental effort, had persistent loathing of food, nausea, and constant headache, and during this time there was a large flow of urine of low specific gravity (1008), showing traces of albumen, and on the third day very slightly bloody. There was no trace of sugar. The wound on the arm after excision rapidly got well. It was believed that the arrow had

been poisoned with wourali (curare), which was shown by the experiments of Claude Bernard, Sibson, and others, to produce effects of a strikingly similar kind to those observed in this case.—*Ibid.*

**ARTERIAL CHANGES IN PHTHISIS.**—The morbid changes in the arterial coats have recently been studied in sixteen cases of phthisis by Dr. N. Sh. Ippa, of St. Petersburg. In all the cases some at least of the arteries were affected, the coronaries of the heart invariably so. The coats which were found to have undergone morbid change were the intima and the middle coat. Connective tissue was found in the intima of arteries where it does not in the normal condition exist at all—as for example, in the brachial, femoral, and coronary arteries. This is due to an inflammation of the coat, which has been described by Dr. R. Thomas as “diffused and nodose chronic fibrous endarteritis.” In arteries where there is connective tissue in the intima, its amount was found to be very materially increased. The middle coat was affected in a somewhat similar manner, the muscular elements being atrophied and connective tissue being formed. The vessels presenting the most extensive morbid changes were the coronaries, and those least affected were the brachial, femoral, and more particularly the pulmonary arteries.—*Ibid.*

**DIGESTIVE FERMENTS IN THE INTESTINAL DISORDERS OF INFANTS.**—It seems somewhat strange, with our present knowledge of digestive ferments, that the application of pancreatin and pepsin in the diarrheas and intestinal disorders of children, especially those arising from inanition, is not more general.

We believe that an extension of the use of these products in such diseases would not only prove advantageous to the practitioner, but would save the lives of many little ones that otherwise would be doomed.

No practitioner, possessed of a modicum of therapeutics and physiological knowledge, will be found to admit that chalk mixtures, opiates, astringents, etc., meet fairly the indications in these cases. The antacids act more mechanically, soothing the irritated mucous coat of stomach and intestines; the action of opiate, which are especially dangerous to administer to nurslings, is uncertain, for it is impossible to gauge their use so as to attain the exact limit essential to intestinal anesthesia and arrest of peristaltic action with-

out narcosis; and astringents, while repressing secretion, at the same time retain and favor the absorption of ptomaines and other poisonous products which have provoked the flux—they limit the dejections at the expense of non-elimination of the toxic.

In such cases, and in all those of enfeebled digestion, and in which the food remains undigested and fermenting in the stomach and intestines, pepsin, and pancreatin, and peptonized foods afford us pure and simple physiological remedies, whose administration is attended with no dangers; and their employment does not preclude the use of cathartics or administration of antiseptics that are anti-toxic to ptomaines.

Recently we have obtained the best results from such treatment, though it must be admitted in cases of unusual gravity, when collapse threatens, that coto and wild yam are sometimes of value to check the flux, the digestive ferment following to secure proper digestion and nutrition. So long ago as 1856, Joulin and Corvisart (*Rec. Med. Chir. de Paris*) outlined this mode of treatment, and claimed the happiest results therefrom; and more recently it was advocated by Trousseau, Pidoux, Barthez, and Rilliet, of France, and Ellis and Davidson, of the United Kingdom. Later still, Dr. J. Milner Fothergill (*Handbook of Practice*, p. 40) remarks of pepsin, “Its utility in the treatment of imperfect digestion and diarrhea in children is certain.” Professor J. Lewis Smith (Professor Dis. Children, Bellevue Hosp. Med. Coll.; *Archiv. Pediatrics*, 1866, p. 518) expresses exactly the same opinion. Professor Frederick John Farre (*Pariera's Mat. Med. and Therap.*, p. 243) commends pepsin “*very highly in cholera infantum and summer complaints of children.*” And Bartholow declares (*Mat. Med. and Therap.*, p. 68), “Very great success has been attained in the treatment of the *diarrhea of infants* by pepsin. . . . The motions will be quickly changed in character, and the nutrition of the child improved by giving it immediately after each supply of food.” He further recommends (Napley's *Medical Therapeutics*, p. 395) the employment of peptonized milk or milk gruel for food in these cases, in which he is supported by Wilson Fox (*Diseases of Children*, ii, p. 821), who considers “pepsin invaluable in gastralgia and all irritation states of intestinal and stomach mucous membranes.”

With such evidence, and with the physiological knowledge that at present obtains, it is evident the digestive ferments are too

little studied or employed. Yet we must admit there have been good grounds for such neglect, in that the pepsins upon the market, for the most part, have been untrustworthy, and with no definite guide for testing, that of the U. S. P. being of a very low standard. These objections no longer obtain, however, for manufacturers have been led to provide accurate tests, and now disseminate the same in their literature. Thus we find Parke, Davis & Co. issue a work on Digestive Ferments that is accurate in all details; and further, they have placed upon the market a new pepsin of higher digestive power than any heretofore introduced, and possessing the exceptional advantages of being absolutely free from ptomaines, readily soluble, and of a digestive power hitherto unattained. Moreover, the standard of pepsin has been raised by the better manufacturers, and it is the practitioner's own fault if he is not able now to secure a preparation suited to his needs.

**EDEMA AS A DIAGNOSTIC SIGN IN CARCINOMA OF THE STOMACH.**—M. C. Baert, of Brussels, writing in *La Clinique* on cancer of the stomach, calls attention to the frequency with which edema of the ankles is met with in this affection after it has lasted a few months—a diagnostic aid which is by no means new, but is, he thinks, in danger of being too much overlooked at the present day. He gives a number of cases recently occurring in the various hospitals in Brussels in which edema was present. In one of these cases the edema came on as early as three months after the first symptoms of the affection made their appearance; in two other cases it was noticed after four months; but in most of the other instances it was delayed till the lapse of from six months to a year after the onset. In one case, where there was no evident cause to which to attribute the loss of appetite and the wasting complained of by the patient, Professor Carpentier, noticing some edema of the ankle, diagnosed carcinoma of the stomach, and found his diagnosis confirmed by the appearance a month afterward of all the usual signs of the affection. Several of the cases presented a marked increase in the nitrogen excreted in the urine. With regard to the deficiency or absence of hydrochloric acid in the stomach in cancer of that organ, Mr. Baert admits that it is usual, but agrees with Wolff and Ewald in saying that this sign is by no means peculiar to cancer, as it is found in other gastric affections.—*London Lancet*.

**DEATH FROM ANKYLOSTOMUM DUODENALE.** In March, 1881, a very instructive history of an epidemic which attacked the workmen in St. Gothard tunnel appeared in the *Journal*. The men became subject to anemia and anasarca through their intestines being infected by a blood-sucking worm. Dr. James B. Hogg, of Woogaroo Asylum, Goodna, Queensland, describes, in the *Australasian Medical Gazette*, February 15, 1889, a fatal case of anemia caused by this intestinal parasite. The patient was a laborer, aged thirty-six, afflicted with secondary dementia following mania. He habitually swallowed stones, which were found in his motions; keys, a penknife, and the bowl of a pipe were passed from the bowels on different occasions. In June, 1885, edema of the feet set in without albuminuria. He recovered; but in January, 1886, the edema recurred, involving the legs and eyelids, and albumen appeared in the urine. In October, 1888, anemia, anasarca, and albuminuria again appeared; he grew worse, and died in December. The kidneys were found to be healthy, as were the heart, lungs, and liver. In the duodenum and upper part of the jejunum were over thirty minute live worms; each was about one third of an inch in length, and adhered by one extremity to the mucous membrane. When detached, a small bleeding point was left behind. Many of the worms were bright pink from newly ingested blood. They proved highly tenacious of life. Dr. Hogg noticed that they wriggled about for some time after being immersed in a one-per-cent solution of perchloride of mercury. The intestines of the patient contained much altered blood. As Hellet has shown, the wounds left when the worms shift their positions continue to bleed. Hence it is easy to understand how a very few may cause fatal anemia.—*British Med. Journal*.

**ADDISON'S DISEASE.**—At a recent meeting of the Montpelier Academy of Science (*Gaz. Hebdomadaire des Sci. Méd.*, No. 11), M. Baumel related two cases of Addison's disease. The first, observed in 1880, was that of a man thirty-six years of age, who had spinal curvature, and in whom the bronzing consisted in an increase of the normal cutaneous pigmentation. The second, observed in 1888, was that of a woman, sixty-five years old, who exhibited marked bronzing all over the trunk, but the face, hands, and feet were exempt. In the first case there was considerable enlargement of the suprarenal capsules and numerous foci of caseation. In the second the capsules were

atrophied and in a state of fatty degeneration, which occurred in other of the abdominal viscera. The change in the capsules was especially marked in one of the two zones of pigmented cells separating the medullary from the cortical substance, and a cavity formed here by the degeneration was the seat of a hemorrhagic effusion. M. Baumel expressed his belief in a chromatic nervous apparatus, and in the function of the adrenals being to supply the material for pigment, in the form of the chemical body discovered by Vulpian. This substance, which reddens in contact with air and blackens with the persalts of iron, would, after contributing perhaps to the formation of hemoglobin, go to form a pigment in the cellular elements. In connection with this subject it may be added that, at the meeting of the Paris Academy of Medicine on the 26th ult., M. Cornil read the report of a committee, consisting of MM. Jaccoud, Constantin Paul, and himself, on a case of Addison's disease with lesions of the posterior spinal nerve roots, communicated to the Academy by MM. Kalindero and Babes. These observers found in this case a chronic sclerosis of the cord mainly confined to the vicinity of these nerve roots, with a neuritis extending specially along the latter, the lesions being most marked in the lower dorsal region. The committee reported that no general conclusion could be drawn from a single fact, but considered this observation to meet the desideratum expressed by M. Jaccoud in his Dictionary, viz., that hitherto no anatomical lesion characteristic of Addison's disease had been found.—*London Lancet*.

**HEMARTHROSIS.**—Mr. Barling showed a man, aged thirty (Midland Medical Society), with hemarthrosis. About fifteen years previously he first suffered from sudden swellings of his knee-joints, arising without cause and recurring at intervals. The elbow-joints and the right ankle also suffered in the same way, the effusion being at times followed by blood staining of the superficial tissues. Several times severe and dangerous hemorrhage had followed from small wounds, and there had also been hematuria, hematemesis, and bleeding from the nose. The patient's father was alive and healthy, but his mother died of phthisis; one brother died, aged ten, from hemorrhage; a maternal uncle was a "bleeder," and had sudden swellings of his joints; a sister's child became bruised very easily. Ten years ago the patient had rheumatic fever, with endocarditis, which produced an aortic murmur. The soft tissues over both knees were thickened, especially on the left side, and flexion

in each was limited to an angle of about 35 degrees. Both elbows were limited in full extension, but the right ankle moved freely. Dr. Winkham Legge had described several joints damaged by hemorrhage in hemophilia, in which thickening and adhesions of the synovial membranes and erosions of the cartilages were found. In one of his cases there was also endocarditis, and it seemed probable that in these patients the marked joint changes were produced by hemorrhage in tissues, very liable to react to slight irritation. This was especially so in view of the fact that the microscopic changes found were similar to those of chronic rheumatic arthritis.—*British Med. Journal*.

**TRANSMISSION OF PNEUMONIA IN PREGNANCY.**—Dr. Netter lately brought to the notice of the Société de Biologie a case confirming the possibility of the transmission of an infectious malady from the mother to the fetus *in utero*. A woman pregnant seven months and a half was admitted into the Hôpital Beaujon for pneumonia of the apex of the right lung. The disease evolved regularly, and on the seventh day desquescence was produced. Two days after the fall of the body temperature the patient was delivered of a child that lived five days. At the necropsy there was found distinct pneumonia of the right upper lobe accompanying fibrinous pleurisy, pericarditis, suppurating cerebro-spinal meningitis, and otitis. Bacteriological examination demonstrated the presence of pneumococci in the lung and in the blood. It was therefore concluded that this pneumonia was clearly hereditary, and not acquired, and that it had been transmitted by the mother to the fetus. Moreover, Dr. Netter demonstrated by experimental proof this pneumonic transmission. A guinea-pig, while pregnant, was inoculated with a culture of pneumococci; these microorganisms were found in the fetus.—*Lancet*.

**THE USE OF ANODYNES.**—To the eye of prejudice every attempt to escape from pain appears to be sinful. The employment of anesthetics during parturition has been occasionally denounced from the pulpit upon scriptural grounds, although it may be doubted whether a similar line of argument has ever induced a clergyman to refuse the offer of "gas" made to him by a dentist. The lengths to which prejudice can go when backed by ignorance are well illustrated in the case of "exalgine," the new anodyne

introduced by Dujardin-Beaumetz and Bardet. Our readers may remember that our Paris correspondent recently sent us an account of this drug, from which it appeared that it was a methyl derivative of acetanilide and that it was possessed of remarkable analgesic properties, particularly valuable in cases of neuralgia. Already this new drug has fallen under the ban of detractors in the lay press. It has been asserted that exalgine is merely a new name for morphine, chosen for euphemistic purposes. According to another view, it will "probably be a running combination of all other noxious concoctions," and will play an important part as a popular substitute for ether, haschisch, opium, and similar medicaments in the treatment of "feverish languor, lassitude, and lowness of spirits." In view of these random assumptions it may be worth mentioning once more that its chemical composition is expressed by the name ortho-methyl-acetanilide, while Dujardin-Beaumetz and Bardet at present only lay stress upon its anti-neuralgic properties without claiming for exalgine the position of a popular panacea, deliriant, or narcotic.—*London Lancet*.

**A DANGEROUS CHLORATE OF POTASSIUM PRESCRIPTION.**—A pharmacist writes to the *Bull. Com.*, January, stating that he often gets a prescription as follows: Chlorate of potassium, 5 gms. (gr. 75); distilled water, 120 gms. (4 fl. oz.); simple syrup, 30 gms. (1 fl. oz.); a dessert-spoonful every half hour. "Children who take this," adds the pharmacist, "always die. M. Bronardel cites six cases of death in children after using a similar potion. Can I refuse to dispense this mixture?" The editor says the pharmacist can not refuse; he can only state the facts to the doctor, "who will be likely to attribute the cause of death to the gravity of the disease." He adds: "Physicians, on account of the scant information we have as to the physiological action of chlorate of potassium, use this medicament with the same imprudence and the same indifference as they have formerly shown."—*American Journal of Pharmacy*.

**RAYNAUD'S DISEASE.**—Dr. Porter exhibited (Sheffield Medico-Chirurgical Society) a patient suffering from attacks of local asphyxia in both hands and feet, independently of exposure, sometimes three or four in a day, alternating with paroxysmal attacks of epigastric pain and vomiting, usually followed by slight jaundice. No hema-

turia, though albumen as well as bile had been present in the urine after an attack, but no reaction with guaiacum test. In the intervals the hands and feet usually recovered their natural color and warmth. No pain in hands or feet during the attack. The patient was a married woman, aged forty-eight. She had had the attacks in the fingers about four months, had not suffered previously from cold fingers or chilblains, and had not been specially exposed to damp or cold. Nine children living; catamenia still regular; family history good; no rheumatism, gout, or ague; abdominal tenderness over epigastrium and left hypochondrium; field of vision contracted.—*British Medical Journal*.

**DIAGNOSIS OF PERICARDITIS.**—M. Puis, of Vienna (cited in *La France Médicale*, No. 27), has drawn attention to the presence in pericarditis (with effusion?) of a limited strip of dullness posteriorly extending from two fingers' breadth above the angle of the scapula to two fingers' breadth below the inferior border of the lung, and limited by the spinal column on the right. Bronchial breathing, bronchophony, and increased vocal vibration occur over this area. But when the patient is in the prone or knee-elbow position, the dullness is replaced by a tympanitic note, the bronchial breathing disappears, and friction becomes audible.—*London Lancet*.

**THE DIAGNOSIS OF HERNIA.**—Dr. Multanovski suggests the addition of a new diagnostic sign to the classical method of diagnosing abdominal hernia. Having made observations on one hundred and fifty-two cases of hernia in Professor Bogdanovski's wards, he states that in all these, when the finger was passed up into the abdomen, a more or less tightly stretched strap-like band could be detected connecting the contents of the sac with those of the abdomen.

**THE LOCAL EMPLOYMENT OF HYDRASTIS CANADENSIS.**—Dr. Felsenburg, of Vienna, strongly recommends the local employment of the fluid extract of hydrastis canadensis in chronic pharyngitis, whether combined with enlargement of the tonsils or not. Having employed frequent daily swabbings out of the throat in a large number of these cases, he found that great improvement both externally and in the subjective sensations invariably followed very quickly. He suggests that similar treatment might be found beneficial in chronic inflammatory affections of other mucous membranes.—*London Lancet*.

**TWO CASES OF PSEUDO-LOCOMOTOR ATAXY FOLLOWING DIPHTHERIA.**—Dr. Morton Prince, Physician for Nervous Diseases, Boston City Hospital, Out-patient Department, writes to the Boston Medical and Surgical Journal on this subject as follows:

Ataxia following diphtheria is sufficiently uncommon to make the two following cases worth recording. The first one is additionally interesting from the fact that the original diphtheritic infection was occasioned by an autopsy wound, and its specific character would have been overlooked but for the later development of a pseudo-ataxia. I say pseudo-ataxia, because the case at first sight had all the appearance of a true posterior sclerosis, and might easily have given rise to much difficulty in diagnosis—as it in truth did at first—as there was the still further coincidence of a history of absence of knee-jerks for some two or three years past.

I. The subject was at the time an interne at one of our hospitals. When he first consulted me there was complete *absence of the knee-jerks*, slight *ataxia of hands*, as indicated by his inability to touch the tip of his nose with precision when his eyes were shut, and moderate *ataxia of legs*. This was sufficiently marked to attract my attention before being consulted, as I casually met him about the hospital attending to his duties. His gait was "jerky," ataxic, and he was unable to draw circles with his toes with normal precision. He *swayed* abnormally with eyes shut and feet together. His hands and legs were slightly *paretic*, though he was able to be about and attend to his duties. The weakness of his legs he was principally conscious of going up stairs. Very slight *anesthesia* of fingers and feet. He complained of numb, pricking feeling in the ends of his fingers. The pupils were normal, and an examination of the eyes by Dr. O. F. Wadsworth showed them to be without change. No atrophy, or muscular irritability to percussion; no paralysis of soft palate, bladder, or bowels; no tenderness of muscles or nerves, or lightning pains. Faradic reaction of muscles good.

In consideration of the statement of the patient that he was confident of the fact that about three years before, when, as a medical student, his attention was for the first time attracted to the knee phenomenon, he had found on testing his own reflexes an entire absence of the knee-jerk, and had never been able to obtain any since, the case had a most suspicious look.

This was October 15th last. Inquiry, however, elicited the following history: About the middle of the preceding August, while making an autopsy on a diphtheritic subject, he had cut

his finger. The accident was followed by swelling and inflammation of the finger and arm; but no membrane developed in the wound. The glands of the arm were noticed to be enlarged. There does not appear, however, to have been any particularly marked constitutional symptoms. About ten days to a fortnight later he had difficulty in swallowing liquids, which regurgitated through his nose (paralysis of palate). About two weeks later still, that is, about the middle of September, he noticed his legs and then his hands began to grow weak. This developed into the condition present at the time of my examination. He never had syphilis.

The subsequent course of the case may be briefly told. The legs began, during the following weeks, to improve, but the hands to grow worse, the ataxia being replaced by a paretic condition of both sensation and motion, so that, for example, he had great difficulty in buttoning his clothes. Grasp of hands, dynamometer L. 60, R. 70. He persisted, however, in keeping about his work, and as long as he did so his hands failed to improve. Finally he consented to take absolute rest in bed, and as soon as he did so he began to improve, and about the middle of December he was practically well. At that time the knee-jerks were still absent, but a few days ago he wrote me that they were "as good as they ever were," whatever that may mean.

The story of Case II may be more briefly told. It was a child four and a half years old. Ten weeks previously he had had diphtheria. Two or three weeks after recovery the mother had noticed a nasal character to the voice. Nothing else was noticed until October 7th, when the boy complained of pain in right ankle, and on the next day the condition present at the time of my first examination (October 19th) developed suddenly, according to the mother, namely, *paralysis of soft palate*, *absence of knee-jerks*, and great *ataxia of legs*. He could walk only with difficulty, owing to inability to control his legs. The legs tested separately seemed to be strong enough to carry him, though there was undoubtedly some paresis. No *anesthesia*, such as would be elicited by the prick of a pin or coarse touch. The age of the patient precluded finer tests. Some awkwardness in use of left arm, whether due to ataxia or paresis difficult to say. No tenderness of muscles or nerves. No atrophy. Head tends to fall forward, and he can only turn it slightly toward median line to right (paralysis), but easily to left. Pupils react very *sensitively* and *irregularly* to artificial light; in strong daylight well, but left less than right, and rhythmical oscillation of pupils can be made out under sat-

ter conditions. Muscles of leg respond well to faradic current.

In the course of the following week the boy grew worse, paralysis rapidly developing, obscuring the ataxy and making it almost impossible for him to stand or walk. As he became too weak to attend the out-patient clinic, the case was lost sight of.

Curiously enough, both cases came under observation at the same time.

The points of interest in the first case are: the paralysis of the palate without primary inflammation of the throat, showing that this is not due to the local action of the poison, as is commonly assumed (Leyden); the infection following an autopsy wound; the accidental association of the disease with original absence of knee-jerks, the latter in itself rare. These cases also suggest the probability that many of the cases of locomotor ataxia reported as cured may be of this kind—a pseudo-ataxy following unrecognized attacks of diphtheria. When occurring in children this probability becomes almost a certainty.

**CHLORIDE OF BARIUM IN HEART DISEASE.** According to *Les Nouveaux Remèdes*, H. A. Haze prescribed the chloride of barium in seven cases of heart disease (once for an infant six years old with lesion of the mitral, once for acute dilatation of the heart, twice for lesions of the aorta, and once for lesions of the mitral in an adult, and twice for functional disturbances of the heart). The results obtained were very good. In all cases the drug slackens and regulates the heart-beat, augments the amplitude of the pulsations without producing as pronounced a tension as the finger applied to the artery feels after digitalis. At the same time the pulse is considerably prolonged. No renal troubles. The author administered the drug in a one-per-cent water solution; one and a half to two grains of this solution repeated three times daily for children, and five grains two or three times daily for adults. In these doses it may be considered as not toxic. As it is, besides, almost tasteless and inexpensive, and acts as rapidly as digitalis, it is to be supposed that this drug will soon render valuable service in the treatment of heart disease.—*Journal de Médecine de Paris*.

**THE TREATMENT OF ACNE.**—Dr. Isaac, assistant to Dr. Lassar's clinic for skin diseases in Berlin, discusses, in the *Berliner Klinische Wochenschrift*, acne and its treatment. As an etiological factor in the production of acne, he considers that hereditary peculiarities in the opening of the sebaceous glands

may have an influence. In such cases the sebaceous duct is wide and funnel-shaped, offering a nidus for dirt and other septic material. Though such anatomical peculiarities may in exceptional cases predispose to acne, its causes are to be sought for in disturbances of the digestive, circulatory, or of the generative apparatus. The treatment in vogue at Lassar's clinic is the following:

Beta naphthol.....	10.0;
Sulph. precipitat.....	50.0;
Saponis virid.....	} aa 20.0.
Vaseline.....	

This salve is applied thickly to the affected portion of the skin either by a brush or spatula, and left *in situ* for from half an hour to an hour. On the following day one notices some desquamation of the epidermis and slight irritation and retraction of the skin. This procedure is repeated every day until desquamation of the entire epidermis has taken place. Should much irritation be produced, the treatment may be temporarily stopped and the affected surface covered with an indifferent powder or with Lassar's paste. For especially stubborn cases the following modification of the ointment may be applied:

Pulv. cretæ albæ.....	5.0;
Beta naphthol.....	} aa 10.0;
Camphor.....	
Vaseline.....	
Saponis virid.....	15.0;
Sulphur precipitat.....	50.0.

The addition of the camphor increases the irritative power of the ointment, which in this form should only be left on the skin fifteen minutes.

Another formula which has been found serviceable in the treatment of acne is the following:

Resorcin.....	} aa 5.0;
Zinc oxid.....	
Amyli.....	
Vaseline.....	10.0.

**CASE OF POISONING WITH ANTIFEBRIN.**—Dr. E. Fürth communicates an account of a case of poisoning with antifebrin to the *Wiener Med. Presse*, April 21, 1889. A girl, suffering with violent hemicrania, took sixty grains of antifebrin. Shortly after taking it nausea, eructations and a tendency to vomit occurred. Milk was given her as an antidote by the bystanders, but was immediately vomited. When Dr. Fürth saw the patient, about two hours after the poisoning, he found her deeply unconscious,

emitting repeatedly cries of pain and complaining loudly of pains in the epigastrium. The face, with exception of the lips, which were somewhat cyanotic, was deadily pale. The skin felt icy cold; the pulse was 140, weak, scarcely to be felt; respiration was superficial and somewhat quickened. Stimulants were vomited, as the milk had been. Altogether the patient vomited fifteen times a greenish-watery fluid. One hour later cyanosis spread to the face, so that four hours after the antifebrin was taken the face was reddish blue. The hands also and the feet were deeply cyanosed, especially the fingers; the rest of the body remained pale. In addition there were symptoms of brain irritation, dilated pupils, spasms of the face, gnashing of the teeth, immobility of the upper and lower extremities, lively delirium, which lasted only a short time but was repeated many times. The patient then sank into deep coma, from which she only gradually aroused after the lapse of three hours.

Eight hours after the poisoning, the patient had become again entirely conscious and complained simply of pain in the stomach and of a feeling of dizziness. The pulse was 84, moderately strong; respiration quiet; temperature somewhat below normal. The cyanosis disappeared first after the lapse of twenty-four hours, fading first from the extremities and last from the lips. The patient was able to leave bed in two days.—*Medical and Surgical Reporter*.

**ANTISEPTIC POWER OF SALOL.**—At the meeting of the Hunterian Society of London, April 10th, Mr. Corner introduced a series of cases illustrative of the antiseptic power of salol (salicylate of phenol) as a dressing for wounds, after the part had been rendered aseptic by a 1 in 20 solution of carbolic acid. He did not claim for it greater power than iodoform and probably other antiseptics have, but he says it has advantages over some. It possesses a pleasant aromatic odor, can be used freely without fear of irritation or poisoning, is absorbent of moisture, which drying forms a hard but friable covering. It will prevent putrefaction; it will not destroy it when once established. It has been used in increasing frequency for several years at the Poplar Hospital, and with excellent results, in compound fractures and dislocations, also as a dressing in amputations, minor and major, and in compound comminuted and depressed fractures of the skull. The first case shown by Dr. Corner was a compound comminuted depressed fracture of the frontal bone, in which the bone was elevated and some spicules removed. Afterward the wound was washed with a solution of carbolic

acid (1 in 20), the opening filled with salol, and a drainage-tube inserted. The dressing was undisturbed for fourteen days, remained sweet, and healed on the twenty-sixth day. His temperature remained from the first under 100°. A second case, treated in January, 1889, was a compound fracture of the olecranon, head of radius, and humerus, opening the elbow-joint, with considerable damage to the soft parts, the elbow having been crushed by the passage of a railway engine over it. The olecranon was splintered and drawn up, causing serious tension of the skin and necessitating removal of both portions. The antiseptic treatment and dressing were the same as in the previous case, but required changing after four hours, and again next day, in consequence of oozing of secretions through the dressing. The parts were then left untouched for thirty days. The temperature went up the day after the injury, and remained about 101° for three days, 100° for two days, and then fell to normal. Two other cases were shown: one a crushed compound fractured finger, dressed twenty-one days before, and not exposed since, there having been neither pain nor elevation of temperature; the other was a compound fracture of the first phalanx of the finger, only dressed at the time of the accident, and left undisturbed for a month, when it was found perfectly healed. Dr. Corner pointed out that this was the common experience in such cases, and that even if gangrene followed the parts remained sweet.—*Lancet*.

**TREATMENT OF OXYURIS VERMICULARIS.**—Gubb, *London Med. Record and Allgem. Med. Centralz.*, recommends rectal injection of pure cod-liver oil, or an emulsion of it with eggs, as reliable and not irritating. Grimaud calls attention to the fact that Lallemant (Montpelier) obtained the most reliable results with natural sulphur waters. He (Grimaud) also had opportunity to convince himself that sulphur water is poisonous for intestinal worms. It may be used internally or per clysmata, and the worms will soon disappear without returning.—*Therapeutische Monatshefte*.

**CREOSOTE IN DIABETES.**—Two cases of diabetes have been treated with excellent results by Valentini by means of creosote administered internally. In one case four drops per diem were given at first, this quantity being afterward increased to ten drops. Under this treatment the sugar disappeared, and did not return when the patient began to eat solid food. The other patient was given six drops per diem, and did equally well.—*London Lancet*.

# The American Practitioner and News

"NEC TENUI PENNA."

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D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } - - - Editors.

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## A VENERABLE DELUSION.

The London Lancet says: "The Prussian army surgeons have been ordered to measure the chests of recruits, especially of narrow-chested ones, every four weeks. All are to be regarded as narrow-chested the circumference of whose chests is less than half the length of their bodies. Narrow-chested men whose chests are not widened by drill are to be regarded as predisposed to tuberculosis, and to be discharged as soon as possible, that they may not infect healthy soldiers."

To the student of modern pathology the above is simply supreme nonsense. German experimental pathology has proved beyond question that tuberculosis is an infectious disease; and while it is an admitted fact that heredity is an important factor in the etiology of phthisis, it is also true that the law of the survival of the fittest will, in the long run, render the descendants of tuberculous ancestors insusceptible to the disease. If phthisis has run so long in a line of descent as to permanently lessen the pulmonary capacity of the survivors, it is clear that these are such as could not be killed by tuberculosis, and are therefore the least likely

to develop the disease. The narrow-chested man may be a bad soldier because of lack of wind; but, if the teachings of evolution and germ pathology be true, he of all others should enjoy immunity of tuberculosis.

1819 DR. SAMUEL BRANDEIS. 1889

This distinguished physician died in his seventieth year at his home in this city on Friday evening, May 24th. He died of disease of the heart, from which he had long been a sufferer. He was a Bohemian by birth, Prague being his native city. He made his medical studies in Vienna, where he was a private pupil of Dr. Hyrtl. He graduated in 1846, and, returning to Prague, engaged in practice. Becoming involved in some one of the revolutions to which Bohemia was particularly prone about that time, he expatriated himself and came to America. He reached Louisville in 1852, and was quickly recognized by the profession here as a man of marked ability. He soon acquired a large business, which he retained to the close of his life.

Dr. Brandeis was a fine representative of the culture, refinement, learning, and taste which have characterized so many of that ancient and wonderful Hebraic race, to which he was so proud to belong. His life was a very useful one outside of its professional lines. He lived it fittingly to its very close. He was in every sense a public-spirited man. He took the deepest interest in all educational matters. He was enthusiastic in his admiration of his adopted country. He filled many places of honor and trust, both in the service of the Government during the war and subsequently in the medical societies and public charities of Louisville. He was a man of simple habits and frugal tastes, and of wonderful industry withal. He loved his profession. He was a great student. He was a practitioner of quick insight, fine judgment, sufficient boldness, and ready skill. In his death Louisville has lost a useful citizen, the profession one of its most distinguished members, and his family their best friend.

## Notes and Queries.

THE FORTIETH ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION will be held at Newport, R. I., June 25, 26, 27, and 28, 1889.

*General Officers:* President, W. W. Dawson, M. D., Cincinnati, Ohio; Vice-Presidents, W. L. Schenk, M. D., of Kansas, Frank Woodbury, M. D., of Pennsylvania, H. O. Walker, M. D., of Michigan, J. W. Bailey, M. D., of Georgia; Treasurer, Richard J. Dunglison, M. D., lock box 1274, Philadelphia, Pa.; Permanent Secretary, Wm. B. Atkinson, M. D., 1400 Pine Street, Philadelphia, Pa.; Local Secretary, Valentine Mott Francis, M. D., New York; Librarian, C. H. A. Kleinschmidt, M. D., Washington, D. C.; Chairman Committee of Arrangements, H. R. Storer, M. D., Newport.

The General Sessions will be held at the Music Hall, Bellevue Avenue, adjoining the Ocean House, and those of the Sections at the Newport Casino, also immediately contiguous, which for the first time in its history, and as an act of courtesy, is permitted by its Governors to be occupied for other than the purpose for which its was built.

The following is the programme of the General Sessions:

### FIRST DAY—TUESDAY, JUNE 25TH.

Assemble in Music Hall, Bellevue Avenue, at 11 A. M.

Meeting called to order by Dr. Horatio R. Storer, Chairman Committee of Arrangements.

Prayer. Rev. Thatcher Thayer, D. D., the senior clergyman of Newport.

Reading names of delegates and others thus far registered, by permanent secretary, Dr. Wm. Atkinson, of Philadelphia.

Announcement of the programme for the day, of halls for the Sections, that papers not already listed be handed to Chairman of Committee of Arrangements for reference to appropriate Sections, that Judicial Council meet at 2 P. M. at Newport Casino, and that, to prevent the usual haste and confusion, the delegates from the different States hold their sepa-

rate meetings to elect members of the Nominating Committee at 9:30 A. M., Wednesday, at the Music Hall, half an hour before the general session.

Address of Welcome by Hon. Thomas Coggeshall, Mayor of Newport; by Dr. Henry E. Turner, of Newport, President of State Board of Health, on behalf of the profession of Newport, and Hon. James H. Eldredge, M. D., of East Greenwich, ex-President of Rhode Island Medical Society, on behalf the profession of Rhode Island.

Presidential Address, Dr. W. W. Dawson, of Cincinnati, Professor of Surgery in the Medical College of Ohio.

### SECOND DAY—WEDNESDAY, JUNE 26TH.

Meeting called to order by the President of the Association at 10 A. M.

Prayer.

Reading continuation of registry list, of programmes for the day, and call for reports of elections to Nominating Committee.

Address on Medicine, by Dr. Wm. Pepper, of Philadelphia, Provost of the University of Pennsylvania.

Report of the Trustees of The Journal.

Consideration of proposed Amendments to the Constitution.

Announcement of Nominating Committee, and that it will report at close of Thursday's general session.

### THIRD DAY—THURSDAY, JUNE 27TH

Meeting called to order by the President at 10 A. M.

Prayer.

Reading of continuation of registry list, and of programmes for the day, and notice that all new business must be introduced at to-day's session.

Address on Surgery, by Dr. Plinius S. Connor, of Cincinnati.

Introduction of New Business.

Report of Treasurer.

Report of Librarian.

Report of Rush Monument Committee.

Report of Nominating Committee.

## FOURTH DAY—FRIDAY, JUNE 28TH.

Meeting called to order by the President at 9 A. M. Prayer.

Reading of continuation of registry list, and programmes for the day.

Address on State Medicine, by Dr. W. H. Welch, of Baltimore.

Report of Necrologist.

Reading names of newly elected officers of the Sections and delegates to Foreign Societies.

Introduction of the president-elect by the retiring president.

Response by the former.

Final adjournment.

*Editors American Practitioner and News:*

NEW PHARMACOPEIA; TOTAL EXTIRPATION OF LARYNX; GERSTER'S URETHROTOME; WHITEHEAD'S OPERATION.—Pursuant to the established custom notices are out relative to the seventh annual revision of the Pharmacopœia. The convention will be held May next, in Washington, D. C. Owing to the rapid strides made by the medical and pharmaceutical professions in the last decade, this promises to be a very important meeting, bringing about the consideration of some very practical questions. A digest of the criticisms upon the present work, drawn from the current literature from the date of its issue to the present time, is to be placed in the hands of the revising committee.

During a recent visit to the New York Hospital, I was shown, through the courtesy of Dr. Wm. F. Bull, a case upon which he had performed a total extirpation of the larynx for a carcinoma involving this organ. The noteworthy feature of this case is the return of voice. So far as the voice is concerned, he has practically suffered no inconvenience from the removal of this organ. The sound of voice, after the removal of the larynx, has been the subject of some very interesting studies made by Dr. Landois and Dr. Strübing (*Erzeugung einer pseudo stimme bei totaler extirpation des Kehlkopfes v. Langenbeck's Arch. f. Chirurgie*, xxxviii, 1.) The points brought forth by these physiologists are, that the consonants and vowels are produced in an essentially normal manner. The voice, consisting of somewhat indis-

tinct articulations, is supplemented by a peculiar characteristic noise, which reinforces both consonants and vowels. This noise does not have its origin at all times in exactly the same place. By the removal of the larynx a dilated chamber is left, which has a constriction above, produced by the root of the tongue in front and the posterior wall of the pharynx behind. In addition to the dilatation so produced, which performs the functions of an air-chamber, there is a strong probability of a secondary dilatation at the upper part of the esophagus for the same purpose. This false voice has a double origin. It has been observed that during the act of speaking there was an approach of the root of the tongue to the posterior wall of the pharynx, and that the principal origin of these false voice-noises was in the first line of the depth between the root of the tongue and the posterior wall of the pharynx. Then, by the encroachment upon the lumen of this construction above, and the forced passage of air from below, there is produced one of the factors in the false voice. In addition, it has been shown that when the base of the tongue is depressed in a forward manner, or protruded and so retained, the voice is entirely lost. The second factor, or consonant formation, is produced by an intense muscular exertion rolling the tongue in a convex shape toward the arch of the hard palate, namely, as by the production of the K (laute) sound (des Gaumen) R and C H. This dilatation, which is exhausted in the production of one or more words, is again refilled by an entirely pas-sive act.

Gerster's urethrotome is the latest addition to the American *armamentarium chirurgicum*. The instrument, in brief, is of an adjustable kind, consisting of what may be called three bars or pieces. First bar is furnished with a canal within its body for the reception of bar number two, and upon its upper surface a groove or cleat for the third bar. At its intra-urethral extremity it is blunt with a recess for concealing the blade attached to the third bar. At its extra-urethral extremity is a thumb-screw to manipulate the dilator, and at the lateral aspect of the same extremity a gauge for recording the amount of dilatation. The second piece, which fits into the canal of the first,

is connected with the thumb-screw at one extremity and at the other is bisected, each segment of which is supplied with a blunt-edged ala. By means of the thumb-screw a projection is made to pass into the split, and by its passage produces a gradually increasing dilatation of the urethral canal. When in use the third bar is drawn forward within its groove, thereby bringing the blade from its recess, and the stricture is divided. The points claimed by the deviser for this instrument over others are, that of its kind it is simpler in construction, is less liable to become out of working order, and is more easily rendered aseptic. The subsequent introduction of a bougie to ascertain the caliber of the urethra after division becomes unnecessary.

*Whitehead's Operation.* I saw this operation performed several times in New York last week, by Dr. Robert Abbe, at St. Luke's Hospital. It is certainly one of the most satisfactory operations in rectal surgery; and in those cases suitable for the operation it is far preferable to the Allingham operation. There is no trouble with hemorrhage or septic infection, the convalescence is rapid and the result most satisfactory.

NEW YORK. AUG. SCHACHNER, M. D., PH. G.

**INDIANA AND KENTUCKY STATE MEDICAL SOCIETIES.**—At the recent meeting of the Ohio State Medical Society, Dr. E. S. McKee, of Cincinnati, said:

*Mr. President and Gentlemen:*

Having been elected as delegate from the Ohio State Medical Society to the State Societies of Indiana and Kentucky, I beg leave to report upon these respective meetings.

The Indiana State Medical Society met in its fortieth annual session at Indianapolis, May 1 and 2, 1889. There was a good attendance, the papers read were of high order and well discussed. This organization meets every year in Indianapolis, which to Indiana is a very central and accessible city. It is a great advantage in many respects to have a permanent and convenient place of meeting. If we had in Ohio so central a city as Indianapolis is to Indiana, I would favor a similar custom here. The one great feature of the

Indiana State Medical Society, however, is the thoroughness of its organization. Eighty out of the one hundred counties of the State have county medical societies. Every county society is auxiliary to the State Society. All members of the county organization are members of the State organization by virtue of their membership in the former. Moreover, they can not become members of the State Society unless they belong to their respective county associations. The Hoosier doctor on his native heath is, as elsewhere, very agreeable, and the social features of the meeting were not neglected. It seemed, indeed, a reunion of friends tried and true. Your delegate was so kindly received that he feels himself and the Society he represents highly honored.

The Kentucky State Medical Society held its thirty-fourth annual meeting at Richmond, May 8, 9, and 10, 1889. This Society is always remarkable for the richness of its programme.

First, they have reports on all imaginable special departments in medicine, about fifteen altogether, two gentlemen being appointed to discuss each report. The programme also had many papers on miscellaneous subjects, each paper having two gentlemen named to discuss it. The programme was so full that two evening sessions were required in addition to the day sessions for its completion.

The meeting this year was a very harmonious one, and the Society is to be congratulated on its safe passage through troubled waters which threatened a bitter schism at the meeting of last year at Crab Orchard. Kentucky hospitality is proverbial, but no one can fully appreciate the term until he has experienced the reality. The good people of Richmond did their utmost to render the meeting in their midst a memorable one. The Ohio State Medical Society was again honored by the many kindnesses showered upon its representative.

We may learn from the Indiana State Society the effectiveness of a body thoroughly organized, and from the Kentucky Medical Society how to compile an excellent pro-

gramme. From both, we, as a State medical society, might learn to be more social, and to closer bind the ties of friendship within our borders.

I am of the opinion that the sending of delegates to the societies of our neighboring States will lead to a more kindly feeling between them and us, and we may gain the knowledge from them how to improve our own Society and to avoid some things which had better be left undone.

CINCINNATI, May 20, 1889.

E. S. M'KEE, M. D.

**MEDICO-CHIRURGICAL COLLEGE OF PHILADELPHIA.**—The following changes have been made in the Faculty: Frank Woodbury, A. M., M. D., Honorary Professor of Clinical Medicine; William B. Atkinson, A. M., M. D., Honorary Professor of Sanitary Science and Pediatrics; John V. Shoemaker, A. M., M. D., Professor of Materia Medica, Pharmacology, Therapeutics, and Clinical Medicine; James M. Anders, Ph. D., M. D., Professor of Hygiene and Clinical Diseases of Children.

**THE CONGRESS OF MEDICAL JURISPRUDENCE** was in session at Steinway Hall, June 5th, 6th, and 7th, with Clark Bell, Esq., presiding. Among the papers read were *Eccentricities of Insanity*, by ex-Judge Noah Davis, of New York; *The Criminal Insane*, by Dr. Samuel W. Smith, State Commissioner in Lunacy; *Medical Expertism*, by Dr. Simeon T. Clark, of Niagara University; *Medical Expertism from its Legal and Medical Standpoint*, by Dr. Le Monnier, of New Orleans; *Live Birth in its Medico-Legal Relations*, by Dr. John J. Reese, of Philadelphia; and *Volitional Insanity*, by Austin Abbot, Esq., of New York.

**THE HOUR OF DEATH.**—There is a widespread popular impression that a very large proportion of deaths from disease take place in the early morning hours—between four and six o'clock. That this is an error is well known to most medical men. From time to time careful observations have been made in hospitals which have resulted in showing that the act of death takes place with fairly equal frequency during the whole twenty-four hours of the day.

Very recently, as reported in the *Journal de Médecine*, of Paris, March 24, 1889, an investigation has been made, which showed that there was a certain falling off of the number of deaths between seven and eleven o'clock in the evening, but that, with this exception, the proportion of deaths is about even.

We refer to the matter because some of our readers may be glad to have authority for correcting a misapprehension which is of no very great importance, it is true, but which is held with great tenacity by persons who are hard to convince of error.—*Medical and Surgical Reporter*.

**DANGER OF THE SUSPENSION TREATMENT OF LOCOMOTOR ATAXIA.**—Dr. Vincent, of Clifton Springs Sanitarium, recently hanged himself unintentionally while experimenting with the Sayre suspension apparatus, which many physicians are now making trial of in the treatment of locomotor ataxia. This unfortunate accident is not the only one, for word comes from France that a man living in the Department of the Dordogne, who was suffering with locomotor ataxia, met his death in the same way. Both these deaths occurred while the persons were alone. The apparatus appears to be free from danger when it is employed under the watchful eye of the physician or in the presence of a skillful attendant.

**THE grand jury** in New York has found indictments for violation of the sanitary law against Drs. Irwin, Ferguson, and Hance, the physicians who performed the autopsy on the body of Washington Irving Bishop, the mind reader.

It is reported that the City Council of Newport, Rhode Island, has appropriated \$3,000 for the entertainment of the American Medical Association, at its meeting there this month.

**THE American International Congress of Medical Jurisprudence** held its first meeting in New York City, June 4th.

**MRS. JANE C. STORMONT**, the widow of Dr. D. W. Stormont, has given \$10,000 to the Kansas Medical Society.

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÄ."

VOL. VIII.  
[NEW SERIES.]

LOUISVILLE, KY., JULY 6, 1889.

No. 1.

*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.*—RUSKIN.

## Original Articles.

### THE PATHOGENESIS OF HYSTERIA.\*

BY JOHN FORD BARBOUR, M. A., M. D.

*Lecturer on Nervous Diseases in the Hospital College of Medicine, Louisville, Ky.*

While an immense amount of clinical material has been collected concerning hysteria, little real advance has been made toward a satisfactory knowledge of the nature of the pathological changes underlying the thousandfold symptoms of this protean malady. The ancient Greek writers were of the opinion that hysteria was produced by the migrations of the uterus throughout the body, pressing in turn upon the various organs, and thus causing the various symptoms of the disease.

Galen exploded this theory by showing the impossibility of such migration. It was then thought to be due to the retention of seminal fluid or blood in the uterus, to the presence of noxious gases (hence the term, "the vapors"), and finally to irritation of the sexual organs. Romberg defined it as "a reflex neurosis caused by genital irritation."

More recent writers have made use of such vague and meaningless expressions as "a peculiar constitution of the nerve elements," "a state of general hyperesthesia of the nervous system," "an exalted excitability of the sensory portions of the brain and cord," etc. These are merely masks to hide ignorance.

Is it possible at this stage of science to

formulate a hypothesis which shall be in consonance with the physiology of the nervous system and the morbid phenomena of hysteria, and which shall be sufficiently definite to have a clear bearing upon the treatment?

I shall make the attempt to formulate such an hypothesis, leaving you to judge of my success.

The action of the nerve-cell was first compared to that of a Leyden jar by Schroeder van der Kolk. When the jar is surcharged with electricity it discharges itself automatically; so, he said, when the tension of nerve force in a nerve cell rises beyond a certain point, an analogous automatic discharge occurs, causing muscular contraction, or sensations, or mental phenomena, according to the character of the cell discharging. The nerve cell may also be compared to a safety-valve which allows the steam to escape when the pressure rises too high.

There are many things which render this theory highly probable. When a muscle is firmly contracted it is not thrown into an absolute tonic spasm, but contracts and relaxes slightly at the rate of twenty vibrations per second. This looks as if it received stimuli from a number of nerve cells alternately filling up and overflowing with nerve force.

There is a determination of blood to the head during cerebral activity, and, as a necessary consequence, increased nutritive activity on the part of the nerve cells and increased production of nerve force.

At times the tension of the nerve force rises so high that it is impossible to prevent its escaping in some direction, as, for instance, in a fit of anger.

The activity of the nerve cells increases

\* Read at the May meeting of the Kentucky State Medical Society, Richmond, 1889.

with increased blood supply, diminishes with diminished blood supply, and ceases with entire failure of blood supply.

Now, normal nerve-cells have a certain capacity for retaining nervous fluid, and this capacity is lessened by any cause which lowers their vitality.

*In hysteria there is a lowered state of nutrition of the sensory cells of the brain and cord, by reason of which there is an incontinence of nerve force on their part.* There is, as it were, a *dynamorrhea*, a diarrhea of nerve force.

The first part of this proposition, namely, that the cells are in a state of lowered nutrition, hardly demands proof. Certainly their nutrition is affected, and certainly it is not in the way of increase.

The second point, that it is the sensory cells alone which are affected, requires more attention. Let us see what results would follow inevitably this incontinence of nerve force on the part of the sensory cells.

All mental and motor action is secondary to and induced by sensory action. If a man could be completely cut off from every sensory disturbance he would sink into a state of absolute inactivity. All action is a reflex of more or less complexity, in which the sensory cells take the initiative. Therefore disturbances of sensory function must produce disturbances of motor and mental function. Dividing the symptoms of hysteria into the three groups of sensory, mental, and motor, there is no difficulty in understanding how an altered state of nutrition of the sensory cells produces attractions of sensation and hyperesthesia of the senses of sight, touch, taste, smell, hearing, and the muscular sense.

Nor is it difficult to understand how disturbances of consciousness arise when the sensory cells maintain a perpetual broadside of nerve force. It is as if the resistance of the safety-valve had been decreased and the steam were escaping constantly under low pressure.

As to the motor phenomena, they are as much reflex in character as a convulsion or contracture produced by the irritation of intestinal worms or a renal calculus. The

difference is this, that in the hysterical patient constant and normal stimuli, which would not tax the tentative capacity of the healthy cells, suffice to produce a sensory discharge. This discharge must produce some effect. It is contrary to the law of correlation and conservation of force that it should not. Force is as indestructible as matter, and must persist in one form or another. The only outlets for this escaping nerve fluid are in the way of sensory, mental, or motor disturbance. Here, then, it seems to me, is a sufficient cause for all hysterical phenomena: Incontinence of nerve force on the part of the sensory cells, including those of special sense, hyperesthesia of all the senses, excessive sensitiveness to moderate and normal stimuli, ubiquitous pains, perversions of the senses, etc.; conversion of this sensory discharge into a motor discharge, tonic and clonic convulsions, contractures; deflection of the sensory discharge into mental channels, emotional incontinence, disturbances of consciousness.

The sensory cells of both brain and cord are involved. There are undoubted symptoms of brain involvement, such as exaltations of psychical irritability, disturbances of consciousness and of the special senses. That the cord is also affected is shown by the following facts: When painful points are strongly irritated reflex spasms are set up in their neighborhood which spread in accordance with the Pflüger law of the reflex action of the cord. The existence of hysterical paraplegias would also point to the participation of the cord.

How can we explain the fact that the same altered state of nutrition will produce at one time hyperesthesia and at another anesthesia, amblyopia, deafness, etc?

Two explanations are possible; the first is that excessive activity on the part of one or more nerve centers will completely inhibit the activity of all other nerve centers.

Again, it is an undeniable fact, however paradoxical it may appear, that a state of depressed nutrition may induce either an excess or deficiency of activity in nerve cells. Gowers says: "It is remarkable that

the same process should sometimes prevent and sometimes permit the liberation of nerve force, but instances of this are familiar to physiologists. The same stimulus, in different degrees, will either arrest or produce reflex action."

What are the causes which will produce this state of mal nutrition of the sensory cells and the consequent premature liberation of nerve force with all the attendant evils? I do not propose to discuss all the causes of hysteria. Their name is legion. Let us direct our attention to a few of the most important points.

Why is hysteria most common among women? In Briquet's often quoted one thousand cases, fifty only were men.

In the first place, the sensory cells of women have less native storage capacity than those of men, however this may have come about.

In the next place, the disease usually comes on about the time of puberty, while menstruation is still a drain to which the girl's system has not as yet accommodated itself. Beneke's researches show that at this time the development of the arteries does not keep pace with that of the rest of the body, and that the female heart is both relatively and absolutely smaller than the male heart.

Locann showed that the blood of women contains more water and fewer red globules than that of man. The proportion of red globules dried to 1,000 parts of blood is in healthy males estimated at 127 parts; in females the proportion is lower, the difference being about 15 parts per 1,000; thence the greater specific gravity of male blood. Here, then, are five causes for the greater frequency of hysteria in women, lesser storage capacity on the part of the cells, the physiological drain of menstruation, insufficient arterial lumen and heart, and poorer quality of blood.

There are two causes which doubtless exert some influence in the production of hysteria, and are more frequent among women. These are lack of proper muscular exercise, and absence of abdominal breathing. The

circulation of blood through the pelves and cranium is largely influenced by the activity of the super-adjacent muscles. Weir Mitchell puts it that each muscle is a little heart, squeezing out the contained blood at each contraction and allowing new blood to flow in at each relaxation. This assistance which the muscular system renders the circulation can by no means be dispensed with. Where the blood does not receive this onward push from the muscles, too little oxygen is carried to the tissues, and the blood becomes loaded with half-consumed products, suboxides, and the nutrition of the whole body suffers.

As to the matter of abdominal breathing, the diaphragm acts like the piston of a pump, creating a certain suction force which exerts a special influence upon the venous afflux from the brain and cord, so that it must have a considerable influence over the nutrition of these organs, as much so as if they were cupped sixteen times every minute.

The uterus has fallen from grace as a factor in the production of hysteria, though few will go so far as Dr. Chambers, who declares that diseases of the uterus have no more etiological import in this respect than those of any other organ.

Of the emotional causes of hysteria, it is the chronic, asthenic emotions, such as worry, anxiety, and the like, rather than the acute, sthenic emotions, such as anger, that induce it.

Education and domestic training exert a vast influence in the engendering of this disease. If the little girl associate too much with adults, if her every whim be gratified, if emotional incontinence be not sternly discouraged, if the control which is exercised over her vibrate between excessive severity and absolute laxity, if she be easily mounted into the follies and follies of a fashionable life, the foundation of a life-long hysteria is slowly building, stone by stone.

The expression of pronounced sympathy for the slight vexations of the weak poltroon, the pauper as indiscriminate giving of money breeds the other sort.

A few words with regard to the treatment.

If the hypothesis advanced in this paper be the true one, viz., that hysteria is due to a lowered state of nutrition of the sensory nerves, then the therapeutic moral is, if you want to cure a case of hysteria you must feed, feed, feed. Do not allow yourself to be tyrannized by a childish and semi-civilized belief in the omnipotence of drugs. You can not supplant the natural processes of health by all the chemical changes you can bring about in the body. "Throw physic to the dogs." There is no *sui generis* nerve tonic nor nerve food.

The brilliant results obtained by the use of dynamic modes show what a little common sense can accomplish. The "boost," if I may use this expressive word, which is given the circulation by massage, electricity, and hydro-therapy, enables the tissues to rid themselves of waste. A genuine peripheral appetite is induced, which is a very different thing from the artificial stomachic craving produced by bitter tonics. At the same time the nervous system is quieted and soothed, and so enabled to appropriate nourishment.

I will relate a case which will illustrate the methods and results of this mode of treatment.

Mrs. K. came under my charge recently. She had been suffering for about three years with symptoms of hysteria and of disturbed digestion. When I first saw her she had a chronic gastro-intestinal catarrh, with hyperesthesia of the lining mucous membrane, pain in the head, pain in the nape of the neck, pain in the back, pain in the stomach and bowels, pain under the left breast, in the left ovary, in the limbs. The uterus was in a state of subinvolution, and was tilted over on to the bladder. She had at times spells of apparent loss of consciousness, lasting from a few minutes to several hours.

She was put absolutely to bed, and one of the excellent trained nurses with whom our city is now blessed was employed. Every morning the patient had a sponge-bath with sea-salt brine, in the forenoon she was massaged, and in the afternoon she had electrical treatment. At first she could not take so little as a teaspoonful of milk and lime-water

every two hours. For the first two weeks she was nourished almost entirely by the rectum. Then she began to take peptonized milk, which was gradually increased up to two quarts a day. To cut a long story short, I give you her dietary at the end of six weeks' treatment. For breakfast, a pint of Phillips' digestible cocoa, several slices of broiled bacon, Graham bread. For dinner, a bowl of soup, slice of roast beef about as big as your hand, cauliflower, asparagus, peas, strawberries. For supper, a large piece of rare steak, Graham bread. In addition, she took a quart of milk at and between meals. She ate all this with relish, was always hungry, slept well, had a free movement of her bowels every morning, gained in weight, color, and strength.

#### SUNSTROKE, WITH REPORT OF A CASE.\*

BY J. G. CARPENTER, M. D.

In the consideration of insolation, the writer desires to give a brief *résumé* of its etiology and pathology, and detail the treatment of a case.

There are three stages of insolation, viz., the syncopal, asphyxial, and hyperpyrexial.

In the syncopal there is exhaustion and failure of the heart's action, depression of nerve force, and prostration of muscular power; the skin is pale, cool, and moist, the pulse quick and feeble. Death may occur suddenly in the state of collapse from heart failure. Complete recovery is frequent.

In the asphyxial or second stage—a condition like shock, in which the nerve centers and especially the respiratory are affected, causing rapid failure of the respiration and circulation from exposure of the head and spine to the direct rays of the sun when the atmosphere is much heated and the nervous energy is depressed by overfatigue, dissipation, or illness—the brain and nerve centers, especially the respiratory, are overpowered by the sudden rise of temperature, and respiration and circulation fail, the failure of the latter being probably due to the inhibitory influence of the vagus.

\*Read before the Central Kentucky Medical Association, April 17, 1889.

Lauder Brunton and Claude Bernard have shown that the effect of high temperature on animals is first to accelerate and finally to stop the heart, leaving the ventricles especially in a state of contraction.

Recovery is often complete, but frequently the trouble results in serious impairment of health or intellect, indicative of structural changes caused in the nerve centers.

Death results from rapid failure of the respiration and circulation.

The third stage of sunstroke is due to the intense pyrexia paralyzing the vaso-motor nerves, and to the nerve centers being overstimulated and then exhausted by the action of heat on the body generally. It may occur either by the direct action of artificial heat or solar heat: it may come on at night or in the shade, as in persons who are exhausted by fatigue, overcrowding, alcoholic dissipation, want of rest, present or recent illness. This stage is characterized by failure of respiration and circulation; unconsciousness; pulse quick, jerking, and feeble; in other cases full, slow, and labored; face, head and neck congested to lividity; the carotids pulsate forcibly; pupils are contracted and eyes set. There is dyspnea, with hurried, gasping breathing; great restlessness, thirst, relaxation of the sphincters, suppression of urine, convulsions, and death. Many of these symptoms are also present in the second stage. Recovery may occur in this stage, though most frequently the case ends in death by relapse or some complication of the brain or spinal cord. The temperature rises to 108°, 110°, or 112° F. In one case of the writer's it reached 110° F., and was rapidly fatal; in another, which recovered, the temperature was 107° F.

On *post mortem* examination there may be no marked pathological lesions in the first and second stages, though in the second there are the following generally: As in cases of shock, the venous trunks, especially those of the abdomen and the right side of the heart, may be found overloaded with blood, and the pulmonary vessels may be too full of blood. The blood is dark, grumous, and is found effused in patches of ecchymoses, rendering the body more or less livid; the coagulability of the blood is

much impaired and is wanting in oxygen. If death terminates in the thermic stage, in addition to the above morbid states the blood is more fluid and grumous, its coagulability is impaired, it is of acid reaction, and is deoxygenated.

The brain and membranes may be found congested. In many cases meningitis is present and serous effusions or hemorrhages into the brain substance exist.

The treatment of the first stage should be removal of the patient to the shade, the judicious use of the cold douche and the use of cardiac stimulants, removal of any artificial constriction of the chest, rest and freedom from exposure to overexertion, fatigue, to alcoholic dissipation, and prevention of imprudence in eating.

In the second stage the above treatment is equally as essential, but the therapeutic measures must be more powerful and continuous, the use of the cold douche or ice applications to reduce the overheated nerve centers and to arouse them into action, the use of stimulants, pure alcohol being the best, given hypodermically. In the absence of the latter, whisky or brandy may be given by the mouth, skin, or rectum.

In the treatment of the thermic stage the great desideratum is to reduce temperature rapidly, stimulate the flagging nerve centers, and to prevent structural changes.

A case of sunstroke in the third or thermic stage will now be detailed. On July 7, 1888, the writer was called in haste, two and one half miles into the country at 4:30 A. M., to see a sick man, mulatto, thirty five years of age. On arrival the case was diagnosed the third stage of insolation. Patient was in the hay-field, three fourths of a mile from any house, water, or ice. From inspection and examination the patient seemed to be in the throes of death; figuratively speaking, the barque containing this spirit was nearing the distant shore of the "river of death," the silvery sails were being loosened, and the golden bowl besetting ere the patient was relieved from an untimely death and premature grave.

This was the state in which the patient was found, viz: Unconscious; pulse quick, feeble,

irregular, 160 to 170, and respiration 60 to 70 per minute; temperature, 107° F.; face, head, neck, and trunk highly congested, so intense as to be livid, and the integument of these regions so hot as to be disagreeable to the hand; the extremities were cold and almost pulseless, appeared exsanguinated; the carotids pulsated violently; pupils were contracted to the minimum; eyes set. There was intense dyspnea, with hurried and gasping breathing, great restlessness and jactitations of the head, trunk, and limbs; the head opisthotonic; relaxation of the sphincters, and at times convulsions.

Having no ice, ice-water, nor antipyrine nor any of its congeners, alcohol (pure), half ounce, was used hypodermically, which was equal to about a gill of whisky. The pulse was made stronger, fuller, and lowered to 150 per minute, though no other change could be observed.

The "lost art" venesection was resorted to with good effect; the patient was bled in the right medio-cephalic vein to the amount of about a quart; the pulse was reduced to 125 and made fuller and stronger; the respiration had become supra-sternal, and tracheal breathing was changed to thoracic and became more regular; the tongue was protruded and was found to be less tremulous; the opisthotonos was also relieved. A messenger with ice from a neighbor's house having arrived, the patient was rubbed continuously with ice over the head, trunk, and extremities, this being continued until the temperature reached 101° F., the respiration 30, and the pulse 100 per minute. Ice applications were applied to the head continuously; but when the pulse, temperature, and respirations would increase, the patient was again rubbed with the ice as described, and a reduction would be made to the former numbers; the pulse, temperature, and respiration were noted every five minutes for three hours, then every half hour for four hours, then every three hours for nine hours. In sixteen hours from the beginning of treatment the patient was conscious, but greatly prostrated; when asleep there was more or less muttering. There was great hyperesthesia of the special senses of sight, hearing, and touch, with perfect control of all the sphincter muscles. Headache and fullness of the head were after symptoms in the case which

called for treatment. Alcohol and tincture of digitalis and muriate of pilocarpine were given freely, the former two to control the heart's action and stimulate the exhausted nerve centers, the latter to cause profuse diaphoresis and ptialism, as the skin and tongue were dry, and to aid the digitalis in preventing suppression of urine. The iodide of potash, grains 10, bromide of potash, grains 30, fluid extract of ergot, dram 1, were given every four to eight hours for two weeks to relieve headache and fullness of head. It was presumed the iodide would cause absorption of any effusion that might have occurred within the brain, and that the bromide and ergot would contract the arterioles and capillaries, diminish the abnormal amount of blood to the brain and restore the blood-vessels to their normal caliber. Blisters were applied every other day for two weeks to aid the above drugs. Calomel, grains 15, followed by broken doses of salts, had to be given every third or fourth day for two or three weeks to maintain a natural state of the liver and bowels. Patient was kept in a dark room, well ventilated, and the intrusion of visitors prohibited. A milk diet enjoined for a week.

The first action of the alcohol was doubtless to stimulate the nerve centers, the second to act on the vaso-motors, nerve centers, and nerves, dilating the arterioles and venules of the extremities and integument, and allowing the blood to circulate freely in these parts. Tension and congestion were removed from the heart, lungs, venæ cavæ, brain and meninges, and abdominal viscera. The heart-beat was reduced in frequency, the heart thereby gaining rest and force. Alcohol is an antipyrretic, and would seem to be the *sine qua non* in such cases.

What are the therapeutic effects of the local use of ice or ice-water in sunstroke? The first effect of cold is to contract the constrictors of the vaso-motor nerves, thereby diminishing the amount of blood in the arterioles; the second, to dilate or relax the vaso-motor dilators and cause an increased flow of blood.

In the case of sunstroke reported, by rubbing the integument toward the feet and hands with the ice, the venous blood was to a great extent prevented from returning to the overpowered

and almost exhausted heart, and from causing greater distension of the *venae cavae*, at the same time the ice increased the flow of blood to the integument and extremities.

Applied to the head and spine the ice had an anodyne and anesthetic effect, as was shown by the speedy relief of many symptoms that were indicative of great pain and agony. The antipyretic effect of the ice-rubbing was wonderful: in half an hour the temperature fell from 107° F. to 106° F., and in two hours to 101° F. Whenever it would rise much above this point, it would again be speedily reduced by the ice-rubbing; ice-water applications or the ice-cap were kept to the head and spine more or less constantly until the temperature was normal and the sensations of fullness or heat of head subsided.

By quickly removing the congestion of the brain and meninges, and of the thoracic and abdominal vessels, ice proves to be the most valuable antiphlogistic in the armamentarium of therapeutics.

In sunstroke the blood is dark, grumous, and is found effused in patches of ecchymoses, rendering the body more or less livid, while the coagulability of the blood is much impaired; ice doubtless acts as a hemostatic, and arrests the further effusion of blood into the tissues and circumscribes the ecchymotic patches in the second and third stages of this disease.

Through the astringent and tonic virtues of ice locally, the overdisturbed vessels and tissues are contracted and toned, and acute congestion is relieved and passive congestion prevented. When treatment was begun in this case, the condition of the patient was so extreme that it seemed the height of foolishness to attempt any cure. The successful termination of it is one of now not a few therapeutic achievements which prove that the physician is the greatest benefactor of man. Though the details of the case may have been long and tedious, the writer believes the importance of it gives them full justification. Through the wonderful potency of the measures employed the patient passed from what would have been speedy death into a new lease on life, and now enjoys good health.

## COMPOUND, COMMINUTED, DEPRESSED FRACTURE OF THE SKULL.

Operation Six Weeks After Receipt of Injury.  
Recovery.

BY LOUIS FRANK, M. D.  
of the Louisville City Hospital House-Surgeon.

On February 19, 1889, Pat Hamilton, a coal miner, aged twenty-six, entered the surgical ward during the service of Dr. T. H. Stucky.

He gave the following history: On January 8, 1889, he was struck on the head with a two pound weight in the hands of an assailant. The blow was repeated, two wounds of the scalp being the result. He experienced no great inconvenience at the time, and the wound healed rapidly. Four weeks after the injury he first began to have trouble.

A severe headache in the front part of the head set in. Occasionally the top of his head would pain him also. About a week after this pain appeared he had an epileptic seizure. There was no history of previous epilepsy, and this was the first ugly symptom in the case. The headache increased in severity and he sought the hospital for relief.

Upon admission on the above date, his temperature was 99° F.; respiration, 22; pulse, 64. Projectile vomiting was present; tongue coated, and when protruded inclined a little to the left. Signs about the eyes other than photophobia were negative. He complained of great pain in the head and dizziness when walking, which was unsteady. There was no modification in the hearing. The bowels and kidneys acted naturally. The man was very quiet, seldom speaking, but sighed frequently. There was loss of power, and anesthesia on left side, more marked in the upper extremity. An ice-cap was applied over the region of the scars, which were found just posterior to the junction of the parietal and occipital bones, and a little to the right. A mercurial was given. After three days had passed with no change, he had a second fit. The respirations became sighing and not more than ten per minute. The temperature gradually

fell to 60° F. and pulse to 48 beats per minute. The anesthesia and paralysis increased, as did the patient's mental torpor.

On February 24th he consented to an exploratory operation, which, by the courtesy of Dr. Stucky, I performed. The physical signs just before the anesthetic was given were, temperature 95° F., respiration 9, and pulse 46 per minute. The man could no longer walk, and compression was evident.

Drs. Allison, Griswold, and Sherill, of the Resident Staff, assisted in the operation, which was as follows:

A crescent-shaped flap was raised of sufficient length to expose both points of injury. Quite a quantity of sero-purulent fluid escaped, and the bone was denuded of periosteum over an area of an inch square. A comminuted fracture of both tables was found with necrosis of the fragments and marked softening of the bone for quite an area around. A granulating mass was protruding, which afterward proved to be from a wound of the dura mater. It was impossible to use a trephine, as the depression of the inner table was so irregular, and the fragments pierced the membranes in so many directions, that the greatest care was necessary to avoid further injury. The only instrument available was an ordinary pair of flat bone forceps, with which the outer and inner tables were cut away until all doubtful bone was removed and the dura had been freed wide of the adhesions, the result of the localized inflammation. This was also necessary as the stellation of the inner table was so great. After the edges of this opening had been smoothed off several fragments of bone were removed from the mass of granulation which were imbedded into the brain substance, one of these being quite an inch in length. The most careful antiseptic precautions were observed throughout, and the wound closed with a continuous catgut suture, a flexible hard rubber drainage-tube being left in the posterior and pendent angle. The physical signs improved at once. A short time after he was returned to bed his temperature was 98° F., pulse 62, and respirations 16 per minute. When the second

dressing was applied on the sixth day, the entire wound had united to the drainage-tube, which was removed. On the tenth day the patient was walking about the ward, having had no elevation of temperature. All the nervous symptoms had disappeared. He says he has no remembrance of any thing that occurred between the second day after he entered the ward and the sixth day after the operation. He was discharged from the hospital, as cured, on the twenty-third day.

The rapid relief following the secondary operation, and the fact that an aseptic condition of the wound was brought about and primary union obtained after pus and necrosed bone were present, make this case of sufficient interest to report.

LOUISVILLE.

## Societies.

### AMERICAN MEDICAL ASSOCIATION.\*

Fortieth Annual Meeting, held at Newport, R. I.,  
June 25, 26, 27, and 28, 1889.

#### OPENING SESSION.

The fortieth annual meeting of the American Medical Association opened under favorable auspices at 11 o'clock, June 25th, in Music Hall, Newport. The large audience room, in which the general sessions of the Association were held, was well filled by the members of the convention and by a large number of ladies and of laymen as well. The platform was occupied by the officers of the Association, ex-presidents, His Excellency Governor Ladd, the chaplain of the day, and the chairman of the local Committee of Arrangements.

The sessions of the convention were opened by the chairman, Dr. Horatio R. Storer, who introduced the president of the Association, Dr. W. W. Dawson, of Cincinnati. Dr. Storer then introduced, as the senior clergyman of Newport, Rev. Thatcher Thayer, D. D., pastor emeritus of the United Congregational Church, who offered prayer.

His Excellency Governor H. W. Ladd was next introduced, and he extended a hearty welcome to the Association.

\* Condensed from Boston Medical and Surgical Journal, New York Medical Record, Journal American Medical Association, and other sources.

Dr. James H. Eldredge, of East Greenwich, ex-president of the Rhode Island Medical Society and one of the oldest members of the American Medical Association in that State, was then introduced and read a brief address of welcome on behalf of the profession of Rhode Island.

The address of the president, Dr. W. W. Dawson, of Cincinnati, was then read by Dr. J. A. Larrabee, of Louisville, Ky. The following is a brief abstract of this address:

The Premier, Mr. Gladstone, after quoting the statistician who estimates the English-speaking people at the close of the next century at one thousand millions, says, "What a prospect is that of many millions of people, certainly among the most manful and energetic in the world, occupying one great continent." This destiny in numbers is startling, but the assertion of Dr. Dollinger, a German scholar, portrays the culture of the future almost as strikingly when he says "that the intellectual primacy of the whole world is certain to fall to the Anglo-Saxon race." Most of that race will be in America.

Looking to such a future, the position of the learned professions is certainly conspicuous—their obligations imperious. Medical men should be loyal to this grand destiny.

An eminent modern critic, in discussing civilization in America, while admitting that we have well solved the political and social problems, asks what have we done to solve the human problem, "the humanization of man in society." The struggle in his own country, he asserts, has resulted in "an upper class materialized, a middle class vulgarized, a lower class brutalized."

We trust that our efforts have yielded better fruit; and since medical science and medical men are prominent factors in society among every people, we may well ask what they have accomplished, what part they have here taken in the solution of the vital problem. In the "Century of Medicine" Prof. E. W. Clark, in his classical address, says:

"It is not an extravagant assertion to say that in all this turmoil, change, and progress (referring to the revolutions and changes in society, religion, and governments for the past

century), medicine has kept abreast of the other natural sciences, of politics, and of theology, and has made equal conquest over authority, error, and tradition." and, it may be added, has contributed largely to man's comfort, happiness, and advancement. To intensify this, reference need only be made to some of our triumphs, to vaccination, to anesthesia, to sanitation, the prevention of pestilence, the lengthening of human life. It is, however, more especially the contributions of the profession in America to which attention is desired at this time. What are we doing in the humanization of man, in the work of civilization?

Are our medical practitioners and our medical teachers what they should be? We shall see. Criticisms abound concerning the defects of medical education. Those who do not condemn, often ridicule; these criticisms and strictures are made for the most part, it must be said, by gentlemen unacquainted with teaching, without any practical knowledge of the constitution of medical colleges, or of the toil, devotion, and sacrifice made necessary by those engaged in didactic and clinical instruction.

These censorious addresses are delivered before and to a body of professional gentlemen, the peers of any, some of whom have grown gray in the hard service; others are still in the prime of life, with reputations coextensive with civilization; the rest are young, full of life and enthusiasm, fired with ambition to render loyal service to that profession which they have chosen. Can our system be so defective? The pessimistic orator seems to forget that he is the product of the system of medical education which he is so severely condemning. Some one has said, "By retrospection and introspection an individual, like a profession, may be benefited." In this self examination we should have but one motive, the elimination of error, the development and support of truth.

The speaker then went on to consider further the subject of medical education, discussing consecutively the physician of the future, medical schools, and the question whether they have increased too rapidly, and the facilities for laboratory work. He touched briefly upon the history of medical teaching in this coun-

try, upon medical journals as the heralds and vanguards of medical progress, on the Medical and Surgical Library and Museum at Washington, the medical and surgical history of the war of the Rebellion, medical societies, and medical literature. He turned for a moment to the "clouds" on the medical horizon and spoke of the proposed legislation for the regulation of the practice of medicine.

The address closed as follows:

The presence of this body of professional gentlemen, representing our entire country, furnishes sufficient argument for the existence of a national organization; one embracing the virtue and strength of the profession, one to which all questions should be referred for just and final decision. Questions will arise, differences of opinion will occur between honest men. We must have some tribunal, some body, to which these questions, these differences of opinion, can be relegated for solution. The golden rule is a principle, not a law; it can not interpret itself. Its application to life in detail must be defined. In this respect we are like other men and other organizations. Our *morale*, however, is higher; it has a zeal, a spirit, a hope and confidence peculiarly our own. If we would have our organization pure, we should make it strong—strong enough to eliminate all that is not true or truthful. We are mortals, not transcendentalists. We can not live as the commune. We must have laws; remembering always that they are not made for the righteous, but for the sinner." "They that be whole need not a physician, but they that are sick." I will not attempt to defend the ethics of our profession. It would be a poor compliment to your intelligence, to your manhood; for there is not a clause in our code which a gentleman could not cheerfully obey. Organize whatever we may please: associations of specialists, of physicians, of surgeons; academies of physicians; congresses of physicians and surgeons; but let us not lose our loyalty to this parent association. Projected almost a half-century ago, when medical societies were few, it has annually convened—in the North, in the South, in the East, in the West, and in the far West, on the Pacific shore; if you will examine its yearly roster,

you will find that it embraced the best and the wisest. Almost all who were present at the beginning are at rest; their places have been filled by worthy men. Thus, new life and new men being added yearly, this association can not grow old.

"When a people hold their lives and property as nothing, the enemy has already suffered defeat." So, too, when virtue will not compromise with vice, the victory, although it may be long delayed, will surely come.

Of the American Medical Association let us unite in saying, *Esto perpetua*.

At the conclusion of the address a unanimous resolution of thanks to Dr. Dawson was passed.

Upon motion, telegrams of greeting, congratulation, and affection were directed to be sent by the secretary to Drs. D. Humphreys Storer and Henry I. Bowditch, of Boston.

#### SECTION OF OBSTETRICS AND GYNECOLOGY.\*

Chronic Cystitis in the Female was the subject of a paper by Dr. Augustus P. Clark, of Cambridge, Mass. The symptoms present in a case of cystitis are often but an expression of the organ that there has occurred a lesion or a morbid process at a distance from the part seemingly affected. Anal and rectal inflammation are not common causes of inflammation of the bladder. Dilatation of the urethra is indicated in those cases where tenesmus is an important symptom, and in which the parts around have been hypertrophied and contracted. Faradism, with one pole over the uterus and the other over the bladder, gives speedy relief. Corrosive sublimate, 1–2,000 will often prove of benefit when no marked organic changes have occurred. Some cases will yield readily, others will require the most ingenious treatment and skillful operation.

A new two-ways catheter was described by Dr. A. Cordes, of Geneva, Switzerland, for uterine injection. His instrument presents the following advantages: It has no tube, no screw, no blind end or *cul-de-sac*, no angles, no eye-lets or corners where the microbe could hide itself, defeating the brush. Being open at the distal end, it throws the fluid into the fundus

\* Reported by E. S. McKee, M. D., Cincinnati.

uteri, from whence it comes down and returns by the exit channel.

Salpingo-ovaritis was the subject of a paper by Dr. Georges Apostoli, of Paris, France. He had treated salpingo-ovaritis by electricity as far back as 1832, and had described it under the name of treatment of *perimetritis*. He thought this trouble should come under the domain of surgery only when electrical treatment has been followed by failure. Castration should be an operation of necessity, never of choice. He claimed for the electrical treatment which he advises, that it is conservative, inoffensive, easy of application by every one, but does not pretend to produce a constant and radical cure of salpingo-ovaritis, and its best justification is found in the fact that a subsequent normal pregnancy follows, as it did in several of his cases.

Benjamin Rush as an Obstetrician was the subject of a paper by Dr. Horatio R. Storer, of Newport, R. I. The introduction of anesthetics in obstetrics was an American idea in the mind of Benjamin Rush fifty years ago. The idea was suggested to him after observing a painless labor in a woman in an epileptic fit, and in another who was drunk. He prophesied the finding of a drug which would relieve the pains of labor.

Boracic Acid in Gynecic Practice was the subject treated by Dr. W. W. Potter, of Buffalo, N. Y. He considered boracic acid of great value in sterility due to acrid secretions which destroy the genital tract fecundating power of the germ. The colorless, odorless, non-irritant properties of the remedy admitted of its frequent liberal and prolonged use in treatment.

Five Hundred Cases of Confinement in a Maternity Hospital was the subject of a report by Dr. Joseph Price, of Philadelphia. The hospital and the treatment conducted within it seemed to be of the highest order, and quite up to the times. He said a few years ago the talk was to abolish the maternity hospitals on account of their great mortality; now the tables are turned, and the mortality is greater in private practice.

The Equine Origin of Tetanus was a point brought out in a report of a case of tetanus

following ovariectomy, reported by Dr. Joseph Tabor Johnson, of Washington, D. C. He could find nothing in his case to suggest an equine influence.

The Kinship of Obstetrics and Gynecology was the subject of a paper by Dr. Thomas O'Connell, of Baltimore, Md. His paper was drawn out by a resolution before the general session to dissolve the Section on Obstetrics and Gynecology, placing obstetrics with pediatrics, and gynecology with surgery. The paper was a very able one, and the resolution was defeated by a large majority.

The address of the president, Dr. W. H. Wathen, of Louisville, was on the subject of Ectopic Pregnancy and Pelvic Hematocoele. He considered that the ovum was never impregnated in the uterine cavity, and thought that the conjugation of the male and female elements occurred before or just after the ovum enters the tube. Ectopic pregnancy is always tubal, with the possible exception of ovarian pregnancy. Abdominal pregnancy can not occur except as a result of primary or secondary rupture.

A successful operation for extra-uterine pregnancy was reported by Dr. S. C. Gordon, of Portland, Maine. This gentleman reported a similar case to this section three years ago. He was of the opinion that a diagnosis of extra-uterine pregnancy could usually be made, though not in all cases. He believes that just as soon as the diagnosis of extra-uterine pregnancy is made we should open the abdomen and remove the fetus. Galvanism he thought simply malpractice. After the paper of Dr. Gordon, which was received with a great deal of enthusiasm, Dr. Wm. H. Taylor, of Cincinnati, with characteristic courage, reported a case successfully treated by galvanism. He thought the diagnosis of this condition very difficult, and the primary interest centers about this point. He gave a concise review of all the late views on the symptomatology, and reported his case in detail to show how closely it followed out the symptoms. From eight to twenty cells were used, and under anesthesia the current was carried to one hundred and twenty five milliamperes. He felt warranted in claiming success for electricity in this case.

Dr. Thomas Opie, of Baltimore, had visited the maternity hospital spoken of and found it unique. He had great hopes for the future in this line.

Dr. Hurst, of Philadelphia, considered the plumbing of great importance. In an infirmary where he practiced he had the closets put in towers, where the ventilation was excellent, and had within twenty-four hours a fall of temperature. He had found the mortality to be very great in tenement houses where the plumbing was at fault.

Dr. W. T. Lusk, of New York, thought that the practitioner should hold himself responsible for the plumbing of the house in which he delivered patients.

Dr. Henry D. Frey, of Washington, D. C., read a paper on The Application of the Forceps to Transverse and Oblique Positions of the Head—Description of a New Forceps. He had sent circular letters addressed to the teachers of obstetrics in the United States, asking their practice in these conditions and the kinds of instruments they used. He gave their replies in a tabulated form. He thought the obstetrician should not content himself with one form of instrument, but be expert with several, so as to be able to use them as occasion demands.

Dr. Wm. S. Stewart, of Philadelphia, read a paper on When Should the Obstetric Forceps be Used, and What Form of Instrument is Required. They should never be used to save time, no difference how busy the busy practitioner was; not to satisfy nervous women or fidgety nurses. We should use the form of forceps best fitted to the particular case. He presented a pair of his make which he had used in a number of cases with good success. In these either blade can be introduced first, the child is not disfigured, and they do not slip.

Dr. Joseph Taber Johnson, of Washington, D. C., thought that women in childbirth should be given all the skill extant, and recited the glories won by the forceps in the lying-in chamber.

Dr. Theophilus Parvin, of Philadelphia, considered this the revival of an old instrument, which will also become an old instrument and be revived by some one else. He thought it

dangerous—that it would crush the child's head. It was an ingenious, complicated instrument, but we want simplicity. The power is too far remote from resistance, for the nearer you can get a horse to the load he pulls, the better he will pull.

Dr. Joseph Price, of Philadelphia, looked upon the forceps of Dr. Stewart as a dangerous instrument.

[TO BE CONTINUED.]

### LOUISVILLE SURGICAL SOCIETY.

Stated Meeting, June 11, 1889, President D. W. Yandell in the chair.

The president presented a case of enlargement of the cervical glands, which occurred in the practice of Dr. Toon.

The disease had existed for eighteen months. In 1883 the patient, then forty years of age, had an apoplectic attack with left hemiplegia. He had had winter cough with some spitting of blood for several years. The patient, of his own accord, began to poultice the growth about ten weeks ago. Since that time the tumors have grown rapidly. His family history is bad. Mother had phthisis; father, chronic bronchitis and softening of the brain. All rational means of treatment except operation have been used. The enlargement is about the size of a cocoanut. There is some superficial softening. He has no pain.

### DISCUSSION.

Dr. Rosenthal, of Ft. Wayne, Ind. (present by invitation), was asked to give his opinion of the case. He supposed the growth would be considered malignant. He had seen cases which showed fluctuation at the surface, but which on aspiration yielded no pus.

Syphiloma, scrofulosis, and tubercle may all be hypothecated of growths like this, but it is probable that nothing short of a microscopic examination will make the diagnosis clear.

In the opinion of Dr. Fink (also present by invitation) lymphadenoma and not cancer should be the diagnosis; this opinion being based upon the fact that cancerous cachexia was not present in the case.

Dr. T. W. Bullock (present by invitation) believed that from the rapidity of the growth that it was sarcoma. He had seen a similar growth opened under cocaine; very little fluid escaped.

Dr. A. M. Cartledge believed the diagnosis lay between malignant and strumous or tuberculous growth. Inclines to favor the latter. The history points that way. Has seen strumous glands as large as these. The patients often appear ruddy. He thinks pus is present. Does not favor an operation. The case might be benefited by treatment, not cured.

Dr. J. W. Irwin (present by invitation) believed it to be lymphadenoma at the beginning, but that it has now taken on a sarcomatous nature. The only chance for the patient is removal of the growth. Believes it to contain serum rather than pus.

Dr. J. M. Mathews referred to a case in the person of a negro girl, sixteen years of age, who had scrofulous enlargement similar to this. Thinks time will confirm like opinion of this. Family history is also confirmatory. Absence of pain excludes sarcoma. Does not favor an operation.

Dr. W. L. Rodman: This case is malignant clearly; variety probably scirrhus; there being no fever, no sweat, no pus, tuberculous neoplasm is excluded. The fluid will be found to be bloody serum.

Nothing except malignant disease would attain such dimensions. The absence of pain in tissues so lax as these of the neck does not exclude malignant neoplasm.

Dr. W. O. Roberts: The diagnosis seems to lie between sarcoma and carcinoma. Latter probably correct. We are not likely to find tuberculous glands in a patient of this age. Growth does not contain pus.

Dr. E. R. Palmer believed the trouble to be no cancerous but tubercular in nature.

Dr. Yandell: This divergence of opinion is remarkable: one says, tubercle; another, scrofulosis; another, malignant disease. My own view of the nature of the tumor is not clear. There are some indications of tubercular disease both in clinical features and history. On the side of malignancy,

is rapidity of growth with the density of the tumors, and involvement of the glands of the opposite side. Age also favors the latter hypothesis. Some light will be thrown upon the diagnosis by the state of the temperature. If under 98°, case is likely to be malignant. If the temperature be not subnormal the growth may be tubercular. Next we should aspirate; probably we will find no pus, but bloody serum. The chances are that the growth is malignant. Individual experience does not say much for treatment. Alternatives such as biniodide of mercury may be used locally with cod-liver oil internally. We might open the tumor and curette it but the patient would probably wear out from continual suppuration and die. An operation in this situation upon a tumor so large, with involvement of the glands of the opposite side (malignant disease being the diagnosis), would give little hope of cure and prove a formidable procedure at best.

Dr. Toon regards the case as one of tubercular adenitis. He does not favor an operation.

Dr. Yandell showed Warner's harpoon, which may be used, in cases in which the neoplasm is solid, for the removal of a piece of tissue for microscopic study.

Dr. J. W. Irwin reported the following case: A brewer and barkeeper, aged fifty-two years, had fractured upper third of the arm. He developed symptoms of pneumonia, and died of heart clot. He was a hard drinker. He doubtless had embolic patches in the lung.

Dr. Yandell quoted from Stimson on fat embolism: Crushed marrow is set free and oily particles dam up the smaller vessels. The first case reported was in a man sixty-four years old. Died in thirty-six hours. He had been kicked on the tibia. Fat was found in the lungs and elsewhere but especially in the lungs.

Busch and Wagner say that this occurs often in fracture; it is not necessarily fatal, may occur and disappear in three weeks after. Patients usually die soon, if at all, but sometimes death occurs late. Fat may appear in the urine.

Dr. Rodman said that Heath, and Holmes also mention the complication. It may happen where fatty tissue was wounded.

Pursuant to a request made at the previous meeting, Dr. Yandell made a report upon delirium after fractures. He had looked up the question in conjunction with Dr. Rodman. They find that delirium of trauma does not seem to be more marked in drinking than in temperate subjects, further than that liquor favors the sequelæ of trauma generally.

E. R. PALMER, M. D.,  
*Secretary.*

### ALLEGHANY COUNTY MEDICAL SOCIETY.

Special Meeting, May 21, 1889, W. F. Knox, M.D.,  
President, in the chair.

Dr. W. P. Munn, of Alleghany, as chairman of the Committee on Health and Disease, read a paper entitled *The Functions and Duties of Health Boards*:

There seems to be an almost universal coincidence of opinion, not only among lay but professional persons as well, that so long as any one disease does not assume a distinctively and overwhelmingly epidemic form there is no reasonable excuse for attempting in any way to limit the spread of preventable diseases. Or, in other words, the function of preventive medicine is to stand idly by with folded hands, waiting listlessly until some terrible scourge fastens itself upon the community before attempting even the simplest hygienic measures. Perhaps this opinion is not openly expressed in words, but general apathetic inaction speaks louder than any set phrase, and the responsible parties must either acknowledge this sentiment or plead guilty to the equally bad alternative of having been negligent in the case of the lives intrusted to them.

There is in the city of Alleghany a very general non-compliance with the ordinances requiring the prompt report of all cases of infectious diseases occurring within the city limits. Physicians are indifferent because the law has never been properly enforced, and because compliance with it has not as a rule met with proper co-operation from the municipal health authorities. The body known as the Board of

Health seems to be of the opinion that its functions begin and end in the investigation of cesspool and similar nuisances, and annually congratulates itself and the city that a merciful Providence has not sent a smallpox visitation upon us, ignoring the fact that typhoid fever, scarlet fever, and diphtheria, each due to entirely different but almost equally preventable causes, slay their thousands where smallpox only numbers its victims by dozens, and that there are other preventive measures than the enforced cleansing of overflowing cesspools. The reasoning even of professional men, who should know better, seems to be that nothing is a nuisance unless it offends the eye or nose, that the cesspool cleaner is the only practitioner of preventive medicine, and that a physician's sole prerogative is to sign death and birth certificates and not bother about any thing else outside of his private practice.

The proposition that every city, and especially every large city, should have a board of health, or a department of public health, requires no elaboration or proof. The duties devolving upon such a body may be viewed from various standpoints, but no practical hygienist would deny to such a body a police power sufficiently strong to enforce its regulations.

Suggestion No. 1 then is: That health inspectors should be known as sanitary police, and as such should, in the pursuit of their duties, have the same emblems of authority, powers of arrest, and privileges of search that are given to other police officers in preservation of the peace. The moral effect of a properly uniformed and efficiently directed sanitary police force would be invaluable in the enforcement of sanitary regulations. Among the duties of a health board we may mention the proper supervision and collection of such vital statistics as are of fundamental importance to the State. All births and all deaths should be reported at once to the health authorities; and here we may make

Suggestion No. 2: This simple routine report might be made the basis for action in the regulation of medical practice, by the authorities refusing to receive or recognize death certificates, other than coroner's cases, when not signed by legally qualified practitioners of med-

icine, this being determined by reference to the prothonotary's list of registered physicians. Proper legislation might also be invoked specifying the signing of death certificates as proper evidence that one is engaged in the practice of medicine. In this manner a local board of health might well find a field for much good work in assisting to limit the number of unqualified or unregistered physicians, and in its executive capacity it might even make prosecutions against such illegal signers of death certificates and receive a revenue from the fines imposed upon them. Further, it is the duty of a board of health to enforce statutory regulations in regard to matters that may intimately or remotely affect the general welfare by becoming causes of disease. In general terms, the abatement of those noxious things or conditions that may become public nuisances, among which we enumerate overflowing cesspools, filthy premises, dead animals, and refuse on thoroughfares, surface drains, open sewers, clogged sewers, and street excavations at unseasonable times and places.

Then may come the adoption and enforcement of such rules and regulations as shall, so far as possible, prevent the spread of infectious and contagious diseases. The limitation of disease seems to be practically neglected by many boards of health, so we present at some length

**Suggestion No. 3:** A sketch of a proposed plan of action for ordinary times, leaving out of consideration those times when some dread disease becomes so prevalent as to call for exceptional measures.

1. Every case of communicable disease should be reported promptly to the Board of Health (age, sex, and residence carefully specified). Measles is included under this head, and mild cases of scarlet fever, sometimes called scarlatina or scarlet rash, are also included.

2. Every such case reported should be marked accurately upon a large scaled map of the city, so that the number of cases in any given square or in any topographical section may be determined at a glance. This map should also have all sewers and water pipes accurately indicated, and diameters marked so that the number of

cases in unsewered districts, in the neighborhood of dead ends of water pipes and in unwatered and partially watered districts, might be known and properly appreciated.

3. A complete list of all cases of communicable diseases, reported during the preceding twenty-four hours, should be sent by special messenger every morning to the principals of all the schools in the city, and, acting on this information, the principals should send home all children residing in the houses from which cases are reported. By this means hundreds of cases of scarlet fever, diphtheria, and measles might be prevented each year, and the number of deaths among school-children largely decreased.

4. Every case of the more serious contagious diseases, viz., scarlet fever, diphtheria, and smallpox, should be visited in less than twenty-four hours after being reported by a medical inspector, who should give personal directions in regard to disinfection, isolation, and attention, and use his discretion in regard to posting an official notice or card on the door.

5. Cases of death from the more virulent diseases should be at once reported, and the funeral should be held under the personal supervision of the health inspector having special police powers. The board should adopt regulations for the preparation, carriage, and disposal of all bodies dead of virulent contagious disease.

Illustrative of the necessity of some such regulations, I will narrate the following instance, occurring in my own practice: In an isolated district, at that time free from any scarlatina, one case of scarlet fever occurred; the medical attendant was lax, the fact that it was scarlet fever was kept quiet, and the child's brother continued attending school for several days. From the same room in the school two other children, living a half and a quarter mile away, and not exposed in any other manner, became sick of the disease, both recovering. From one of these children five others, one in the same house and four living next door, contracted the disease, and two of them died. Then the outbreak ceased. I can not help thinking that, had the first case been promptly reported and the brother kept from

school, the other cases might not have occurred.

The health authorities should have an intelligent understanding of water supply, sewerage, disposal of waste material, etc., and should have sufficient authority for the sanitary control of these departments.

The recommendations of the health officers, if based on the prevalence of disease in unsewered or partially sewerred districts, as conclusively shown by the map process previously detailed, would be of great weight in determining the location, size, and drainage area of sewers. In relation to water supply it would be equally weighty.

For example, such a graphic illustration of the number of cases of typhoid fever in the triangular space bounded by Ridge Avenue, Alleghany Avenue and Rebecca Street, and the number of resulting deaths would, when taken in connection with the imperfectly-sewered condition of the district and the accumulation of surface water there, be productive of prompt action provided that an intelligent medical health officer and an intelligent sanitary engineer co-operated in the work. Again, a similar graphic illustration and statement of the percentage of preventable sickness in the totally unsewered hill district of Alleghany, having an estimated population of eighteen thousand, might be productive of good results.

I would give a detailed description of these districts and a detailed statement of the cases of communicable diseases occurring in them if there was any likelihood of correct figures being obtainable, but such a statement is impossible.

Lastly, I would suggest consideration of a matter seldom taken into account by health boards, and of material interest to the mass of our people, although the suggestion may savor somewhat of the paternal methods of European authorities. Some effort should be made to regulate house building, in reference to the number of cubic feet of air in rooms, in reference to ventilation, methods of house sewerage, etc. Small tenement houses should be numbered and have tickets or placards attached indicating their air capacity and the number of persons who should be allowed to live in them.

This plan is pursued with much benefit in the city of Glasgow, and also, I believe, on the Continent. That proper supervision in this matter would tend to give healthy homes to the working classes, and in that manner lessen disease among them, I am fully convinced.

In conclusion: This paper is a plea for the introduction of scientific methods in municipal hygienic procedures, for the placing of trained, scientific workers in positions now filled by political strikers, and for a careful and conscientious fulfillment of the responsibilities voluntarily accepted by those who profess to care for the lives and health of a public which is only too ready to be victimized by unscrupulous and conscienceless politicians.

Dr. Thomas: I indorse all that was said, but I am sorry the measures advocated in the paper will probably not be enforced within a hundred years. I have been connected with the Board of Health of the city of Pittsburgh for a number of years, and I know the difficulty encountered in trying to enforce any sanitary law. It lies not only with the medical profession but also with the laity. The laity can not understand why these things should be; they think these diseases are punishments sent by the Almighty, and that any thing that men could do would not forestall the appearance of these diseases. The laity need instructions before they can appreciate the necessity of these laws. I am also connected with the School Board, and I know the difficulties we have there in preventing children from going to school in whose families contagious diseases exist. The rules of the Board of Health of this city are, that children can not go to school until thirty days after convalescence from one of these diseases, but these rules are frequently violated. So long as we do not have a fearful epidemic the laity pay no attention to isolated cases. On the South Side, so long as we have continuous freshets, we get fresh and pure water from the mountains of West Virginia, and are comparatively free from typhoid fever. For the last year I do not think we have had a dozen cases of typhoid fever on the South Side; but there may be a return of the circumstances we had last fall a year ago, and then we shall have a fearful epidemic.

Now, as I say, we have had for the last year no typhoid fever; the people are apathetic; they have not arisen to the fact that the same condition exists now, as far as the river is concerned, and we shall have another fearful epidemic of typhoid fever. The South Side Medical Society, during that epidemic, discussed the subject fully and had published in the Pittsburgh papers articles showing plainly the cause of the epidemic. Nothing was done; nothing will be done until we have another epidemic and we go over the same thing again and again.

Dr. Munn: I would make only one remark in reference to the report, and that is, that the health administration of Pittsburgh may not be what it should be, but I would esteem it a peculiarly fortunate thing if the city of Allegheny were to have, for one year only, a health administration as efficient as exists in the city of Pittsburgh.

Dr. Buchanan read a paper, entitled "Two Uncompleted Ovariectomies; One Fatal."

Dr. McCann reported two cases of nephrectomy. He said:

I operated upon a case of movable kidney. The kidney could be readily detected in the abdomen above the umbilicus, could be pushed beyond the median line and downward to the anterior superior spinous process of the ilium. The woman was emaciated and weak; had suffered constant pain, sickness at the stomach, and abdominal tenderness. The kidney was easily reached by the lumbar incision, and pressure upon the abdominal wall in front brought the kidney into its normal position. The peri-renal fat was divided and the true fibrous capsule exposed. The ease with which the kidney could be grasped and held was remarkable, and demonstrated the advantage of the lumbar operation for the removal of the kidney when not enlarged beyond double its normal size. After pushing the tumor down to its normal position, freeing it from peri-renal fat, four strong silk-worm gut sutures were passed so as to include the capsule and cortical structure of the kidney, the lumbar fascia, and a portion of the deeper muscles. The kidney was held in its normal position, and the ligatures were drawn tightly and tied, their ends

being cut short and left in the wound, and the kidney thus securely "anchored" in its natural location. A drainage-tube was placed in the wound, the entire wound united by silver sutures passed deeply through the muscles, and an antiseptic dressing applied. No shock followed the operation, and there was no rise of temperature except on one occasion when it reached 101° F. No renal disturbance whatever followed. The wound united kindly, the drainage-tube was removed on the seventh day, and thus far the patient has progressed very favorably. A pad is still worn over the abdomen to support the kidney.

The second case was one of supposed cancer of the kidney. A tumor existed in the right loin, extending almost to the umbilicus and down to a little below the anterior superior spinous process of the ilium. It was very painful, and had been noticed first eight months ago. A careful microscopical examination of the urine, which was loaded with pus, apparently revealed the presence of cancer cells, and the case was supposed to be one of cancer of the kidney. There was an obscure sense of fluctuation in the tumor, and on exploring with a hypodermic syringe a quantity of pus was withdrawn. The patient was etherized, and an incision through the muscles in the loin exposed the surface of the kidney. The incision was deepened in the direction of the fluctuation through a portion of normal kidney structure. About a pint and a half of thick, not unhealthy looking pus was discharged. The wound in the kidney was enlarged and the pelvis and calyces explored in every direction, in the hope of being able to detect a calculus, but none was discovered. A large drainage-tube was placed in the wound and an antiseptic dressing was applied. During the first forty-eight hours there was a copious discharge of pus, but this has gradually diminished. Two weeks have now passed since the operation; the woman is able to sit up, to walk, and is free from pain; the enlargement has almost disappeared, and her health is steadily improving.

Dr. McMullen: I have had in my practice, since March 10th, eight cases of cerebro-spinal meningitis of the epidemic variety. The whole

number of cases have existed in five families and about five squares apart. Three cases have been fatal, one after five hours, one sixteen hours after first symptoms, and one twenty-seven days after the first development of symptoms. One has recovered with the loss of the sight of one eye, and I think there will be some permanent disability of the left leg. The treatment consisted of calomel and rhubarb for purgation, and of large doses of bromide and iodide of potash. For pain, opium and belladonna were administered.

Dr. Kearns: We had an epidemic of cerebro-spinal meningitis three years ago. At that time I had a number of cases. I became convinced that quinine was the great remedy. Symptoms are to be combated as they arise, but as to the general treatment quinine is most efficacious. I have my doubts about its being an infectious disease.

Dr. Thomas: I have used chloral I suppose the last twelve years in cases of cerebro-spinal meningitis, and I approach these cases now with a great deal of assurance. It must be given in large doses; not in five-grain doses or in forty-grain doses, but in doses sufficient to control the symptoms; that is, the dose may be five grains, it may be twenty.

Dr. Stewart reported a case of stricture of the urethra: I desire to report a case of stricture of the urethra which has some interesting points. The patient came to me with a history of having contracted gonorrhea four months previously, which soon became a gleet. His principal trouble, however, was a difficulty in beginning the act of micturition associated with a difficulty in completing the act, owing to spasmodic contractions of the compressor urethræ muscles. During the past three months he had been subjected to a course of introduction of sounds without benefit. I examined his urethra with the urethrometer and found it to have a caliber of 40 F., but at the meatus there was a contraction to 34 F. I incised this stricture to 40 F., but did not introduce a sound, as at that time I had none sufficiently large to be of any service.

Three days afterward the patient returned and reported that from the time his meatus was cut the trouble in urinating had ceased.

The gleet was subsequently cured by the introduction for a few times of a No. 38 and 40 F. sound. The interesting point in his case is the interference a stricture of the meatus capable of admitting a No. 34 sound may exert on the act of micturition, and the immediate relief obtained by removal of the stricture.

I have so often observed the beneficial effects obtained by cutting the meatus where it is contracted, that I make it a routine practice in the treatment of chronic urethral troubles, to cut the meatus if contracted, preliminary to the further treatment of the urethra. In cutting the meatus I do not follow the directions of the authorities, to cut the flaccid penis, but insert a bivalve meatoscope and cut the meatus when rendered tense. By this means there is less pain and the incision is more likely to be vertical than if the tissues were not put on the stretch.

Dr. Thomas: We know that various conditions about the penile organ produce reflex troubles. Where a stricture of the urethra exists, and it becomes necessary to incise it, the rule is to afterward pass full-sized sounds in order that the incision may be filled in with a plug of new tissue; if we do not do so, when the parts have healed they remain as they were before the cutting. As the doctor did not follow this rule, but at the same time succeeded in curing his patient of his symptoms, I suspect that these were of reflex origin. The mere fact that the patient's previous attendant had passed a pretty full-sized sound amounts to nothing. Every penis has its own standard as to the caliber of its urethra. Some time ago I treated a young man about twenty years of age, who required a No. 40 F. sound before his strictures were completely dilated.

I agree with the doctor that when the meatus, or a stricture immediately back of it, needs cutting, it is correct to put the parts upon the stretch. I usually do this little operation with the Otis urethrotome inverted. By thus putting them upon the stretch the incision is more precise, and less bleeding follows.

Dr. LeMoyne: Diseases of the urinary passages are characterized by such a great variety of demonstrations that unique cases are frequently encountered. It is a fact very gener-

ally admitted, that simple incision of urethral stricture is almost invariably ineffective. On the contrary, it must be followed by repeated dilatations to prevent the primary union of the divided tissue and secure the development of a cicatricial tract by granulation, with the effect of increasing the caliber of the canal at the contracted portion. With all due regard to the observations reported in this case I am disposed to attribute the irritation to a diseased filament of nerve which was divided by the incision.

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### Correspondence.

#### PARIS LETTER.

FROM OUR SPECIAL CORRESPONDENT.

A subject of great interest was lately introduced at the Academy of Medicine by Dr. Worms, on diabetes, its slow evolution, its prognosis, and its treatment. The extent of his memoir will not admit of giving even an analysis in this letter. I may, however, reproduce his conclusions: (1) In the present state of science, a theory absolutely satisfactory of diabetes and applying to the majority of cases does not exist. (2) A rigorous classification between the different clinical aspects under which it presents itself is very difficult to establish. (3) We might, however, distinguish a grave form, rapidly fatal, and a form of slow evolution. It is the second which is the most commonly observed in private practice. It is susceptible of cure and permits of long life. (4) Its treatment should consist in the principle of maintaining at its maximum vital energy, and of favoring the integrity of the digestive functions. (5) The addition of the sulphate of quinine to the alimentary *régime* formulated by Bouchardat most frequently fulfills these indications. MM. Dujardin Beaumetz and Germain Sée took part in the discussion. Contrary to the opinion of Dr. Worms, these authors considered diabetes a distinct malady and not merely a symptom. In a practical point of view their conclusion consists principally in completely proscribing milk from the diet of diabetic subjects and of prescribing from 150 to 200 grams daily of fat, sardines, herrings, and, according to M. Sée, green vegetables, the crust of bread which he says gives only the illusion of an aliment, containing as it does 87 per cent of

water. None of the authors approved of gluten bread, as it contains a good deal of starch. Dr. Worms condemns the use of saccharine as a substitute for sugar, which it can not replace, as it is not an aliment. Dr. Dujardin-Beaumetz replied, that, while agreeing with Dr. Worms that saccharine is not an aliment, he found it a very useful substitute for sugar, and the quantity necessary for sweetening purposes is so small that in his experience he has never observed any deleterious effects from it. By way of medicaments Professor Sée recommends nervines, such as opium, belladonna, and antipyrine. Dr. Albert Robin followed in the discussion, and recommended antipyrine in the treatment of diabetes, for which affection he considers the drug almost a specific. It should be administered in doses of one gram, to be repeated three times a day at intervals of four hours. As much as possible it should not be given too near the meals, as Dr. Robin has observed that it sensibly diminishes the activity of the gastric juice. Antipyrine should not be employed pure, but it should be mixed with an equal quantity of bicarbonate of soda. After six or eight days of treatment the symptoms of diabetes are notably attenuated, the sugar is considerably diminished, the drug should be suspended and the classical *régime* should be commenced. When the patient is fatigued of this *régime*, or when the latter does not produce any more effect, the antipyrine should be renewed for a period of six or eight days. This alternating method, consisting in the judicious employment of antipyrine and of diet, is considered by Dr. Robin as the best treatment for diabetes we possess at the present time. It, however, does more harm than good when there is much emaciation and pallor or swelling of the eyelids. The medication for diabetes, as recommended by Dr. Robin, may be thus formulated: Withdraw from the organism by an appropriate *régime* the materials of the formation of sugar and deprive the hepatic cell of its exciting function. Slacken general disassimilation and the formation of glycogen by the aid of therapeutic means which diminish

the chemical acts of organic life by the intermediary of their primary action on the nervous system.

Professor Ollier, of Lyons, recently read a note at the Academy of Medicine having for its title, On the Conservative Surgery of the Past and the Previous Section of the Astragalus in the Resection of the Instep. The original idea of this method consists in doing the contrary to that which has hitherto been done, that is, to remove the astragalus, which was formerly preserved, in order to render the search for morbid products more easy. The ablation of the astragalus always leads to a definitive cure. The hollow left by the resected bone soon fills up, and the foot resumes its original consistence. M. Ollier has operated, after these new principles, on about fifty patients; the success was general. A woman from whom he had removed the astragalus was lately able to make thirty kilometers on foot. Another patient accomplished seventy-three kilometers without any special shoe. These results, concluded M. Ollier, speak for themselves.

After establishing its proper place in medicine "massage" is tending more and more to enter into practical surgery. Dr. Raffin, in a very interesting work entitled "Clinical Study on Massage Applied to the Treatment of Juxta-articular Fractures," demonstrates that massage applied to juxta- and intra-articular fractures does not deserve the oblivion in which it was allowed to fall and the contempt which has been manifested for it in leaving it to the monopoly of bone-setters and sorcerers. According to the author, massage favors the resorption of the extravasated blood, and by this act itself it hastens the work of consolidation. It facilitates the recuperation of the functions of the limb, prevents the organization of plastic products and the production of muscular atrophy. Massage was accused with interfering with the process of the consolidation of fractures and of producing deformity, but the observations of the author permit one to respond to the first reproach; as to the second, it may be answered that it is always possible to have recourse to appropriate apparatus if

the deformity should threaten to be reproduced. The pain produced during massage should be attributed to the operator and not to the methods. In operating with gentleness and moderation it might be applied to almost all cases. Dr. Gaudin vaunts massage in gynecological practice. He has employed it with success in all chronic and atonic uterine affections, inertia of the uterus and its consequences (amenorrhea, dysmenorrhea), neuralgia of the true pelvis, fatty accumulations of the genital organs of the female.

In the *Revue d'Hygiène Thérapeutique* Dr. Breuillard has published an interesting article on pneumatic massage, in which the author gives curious revelations on massage in China. Massage is there an absolute current practice which replaces the different means of revulsion and of derivation in use in Europe. The "masseurs" form numerous corporations, of which the blind form an important part; they go about the streets announcing their presence by peculiar cries. Their services are often called into requisition, a simple indisposition or contradiction induces people to have recourse to massage. "The Chinese appear to know better than we do all the centers of reflex action which the skin possesses."

PARIS, JUNE 7, 1889.

### LONDON LETTER.

*Editors American Practitioner and News:*

I have been in London now two weeks, and have found much of interest. Some of the special clinics here are held in the morning, which is of great convenience to the visitor. In New York all the eye, ear, and throat clinics are held at the same time in the afternoon, thus giving the visitor but a few hours of the twenty-four in which to work. Of course the material is without limit. To find a little that is profitable it is necessary to go through many, many cases.

I shall, next week, be made assistant at the Throat Hospital, with which such men as Sir Morell Mackenzie, Drs. Hovell, Wollenden, and Bond are connected, when the advantages for closer relationship with the patients will be much increased.

Here is one very interesting affair which occurred at one of the large hospitals last week. A child, four years old, had advanced vegetations removed from the pharynx. A twenty-per-cent solution of cocaine was sprayed carefully into the pharynx. In a little more than one hour the child died of cocaine poisoning. It had tetanic convulsions; ether was injected hypodermically, and amyl nitrate with other remedies used with no effect. This is the first death I know of from the use of cocaine in this manner. When at home the removal of adenoid tissue from the pharynx is an almost daily operation. In young children I use no anesthesia whatever, neither local nor general. It has always been my experience that cocaine used in the nose or pharynx, and especially in the first, produces more depression than when taken internally; a very much smaller dose will produce the effect. When I use it in or about the nose I first give some stimulant. I have frequently had adults, whose noses I had sprayed with a small quantity of a four-per-cent solution of cocaine, to remain in my office an hour or more because of its depressing effects. I had, one day, a great, stout, healthy farmer to drop at my front gate from the use of a small quantity in the nose. I give directions that the patients must not swallow any of the solution when it is sprayed into the nose, and feel sure the depression is from the local action of the drug upon the superficial sympathetic nerves of the lining of the nose. The sympathetic nerves and ganglia here are quite superficial. I believe one grain of cocaine applied to the mucous lining of the nose will depress more than three or four grains taken into the stomach. The case I report above is supposed to have had sprayed into the throat from three to five grains; the quantity can not, of course, be gotten at accurately.

The Englishman, with his conservatism, is of course slow in taking up advances in surgery as in other matters. I find all who I have seen operate for cataract doing the old operation, that is with an inflexible eye. A great majority of the American operators abandoned it some time ago, and have the same number of successes, with better vision, and of course much less deformity. I have as yet not had

the courage to inquire of any of the ophthalmic surgeons here their reasons for not adopting the new operation, yet I am sure if I should I would get a prompt and civil answer, as I have yet to find an Englishman or an Englishwoman who will not answer promptly a civil question. Even with the lower classes your questions are answered promptly, and with a tip of the hat. It shall be my pleasure as my trip progresses to keep the readers of the Practitioner and News posted as to any thing new that may come under my observation.

W. CHEATHAM.

LONDON, ENG., June 4, 1889.

### Translations.

UNDER THE CHARGE OF I. N. BLOOM, A. B., M. D., DERMATOLOGIST TO LOUISVILLE CITY HOSPITAL, MASONIC WIDOWS AND ORPHANS' HOME, ETC.

**GLYCOSURIA AND ANTIPYRIN.**—(Paris Academy of Medicine, April 2, 9, 16, 1889.) M. Panas treated a patient suffering from diabetes and cataract. After placing him on a dietetic course he was given 3 grams (45 grains) of antipyrin daily. After six days of treatment all traces of sugar had disappeared and the cataract was successfully operated upon. During the next six days only 2 grams (30 grains) of antipyrin per day was given, and, in spite of the fact that the patient was allowed to eat bread, sugar did not reappear. When no antipyrin had been given for two days sugar reappeared to the extent of 5 grams (75 grains) in twenty-four hours.

Another patient, sixty-three years old, and diabetic for six years, had a cataract in the left eye. For a week she received 3 grams of antipyrin daily. The amount of sugar was diminished from 35 grams (9 drams) to 3.60 grams (55 grains) per 1,000 grams (32 ounces) of urine. When the dose was decreased the quantity of sugar became larger. The operation for cataract was successfully performed, and 2 grams of antipyrin then kept the amount of sugar down to .60 centigrams (9 grains.) When no medication had been given for nine days, 6 grams (90 grains) of sugar per 1,000 grams (32 ounces)

were found. Panas' conclusions were: (1) Antipyrin exercises a prompt anti-glycogenic effect. (2) It is efficacious when the usual remedies prove valueless. (3) In the beginning 3 grams daily are necessary. (4) The effect is produced even when amy-laceous food is given at the same time.

M. Germain Sée, after treating eighteen patients, comes to the conclusion that antipyrin often effects a complete cure when the amount of sugar does not exceed 80 to 100 grams (3 to 3½ ounces) and even when diet is not strictly followed; on the other hand, it does no good where the patients are very much wasted and their urine contains more than 150 grams (5 ounces) of sugar. It is also of no value in phthisical diabetics.

Nephritis does not follow the use of antipyrin, and albuminuria ceases when the drug is withheld. Dujardin-Beaumetz thought that antipyrin could be used with benefit in all cases of nervous origin and accompanied by polyuria. Nevertheless it should not be used alone to the exclusion of other drugs.

A. Robin, while acknowledging the benefit derived from antipyrin in glycosuria, polyphagia, polydipsia, and polyuria, denies its curative effect in diabetes. It can be administered with benefit: (1) In the beginning of treatment in order to lessen the glycosuria and polyuria. (2) In order to allow a change in the treatment. (3) When the previous treatment has attained its maximum of effect. (4) When it is desired to modify the severity of diet. (5) When it fails in bringing about a rapid diminution of the glycosuria it should not be persisted in. (6) Only when the specific gravity falls or remains stationary after the amount of daily urinary excretion diminishes is antipyrin indicated; when the specific gravity rises the administration of antipyrin should cease. (7) Albuminuria is no contra-indication; it should only influence the dose and duration of its continuance. (8) Even when the glycosuria is favorably influenced the contra-indications to its use are, loss of appetite, loss of flesh, debility, pallor, swelling of the eyelids, palpitation, feeling of tension in the face.

**A CASE OF SEVERE ACUTE PEMPHIGUS; RECOVERY.**—(Prof. Struempell, *Munch. Med. Woch.* 1888; *Memorabilien*, May, 1889.) Bullæ first appeared on the thighs of a forty-two-year-old mason in May, 1887, and spread slowly over the buttocks, genitals, and upper extremities, accompanied by decided burning and itching. New bullæ constantly appeared and their excoriated sites became superficial ulcers. Temperature over  $104^{\circ}$ , appetite and general condition bad. The patient looked so wretchedly that in the beginning the prognosis was very unfavorable.

Internal medication was entirely without effect. Arsenic was not given, because in other cases its administration had not been productive of benefit. Large doses of salicylate of sodium (10 grams— $2\frac{1}{2}$  drams daily) and atropin (3 milligrams—1.20 grain daily) were given for a long time without effect. Beginning with the first of July the bullæ were opened as soon as possible. This procedure was a very wise one, as it prevented the spread of the bullæ and brought about a quicker healing. Afterward the patient was given a warm bath daily for one to two hours. The diseased portions of the skin were dressed, some with dry salicylic acid powder, and others with bichloride of mercury solution (1 to 2,000). The excoriated places healed rapidly under this treatment, no new bullæ appeared, and on July 20th the patient was dismissed cured. Bacteriological investigation only gave negative results.

**THE NEW ANTISEPTIC METHODS IN THE TREATMENT OF TUBERCULOSIS**—(Dr. A. Bochman, *St. Petersburg Med. Woch.*, 1888.) The writer gives a review, partly critical, partly as reference to the therapy of tuberculosis of the lungs from the time when Koch's discoveries cleared up the etiology of the disease. Immediately after the discovery of bacillus every effort was directed to find the some remedy which would destroy it, and a host of such were brought forward, many of which had formerly been tried, unfortunately the results have all been of a negative character. Bochman places these attempts in various categories.

1. *Inhalations*.—As early as 1664 Bennett proposed to treat consumptives by inhalation of different solutions. Bilard recommended in 1774 the smoke of burnt tar, and Mulge in 1780 prepared a special apparatus for this purpose. Tissot, Meul, and Willis at the end of the previous century, could not find praise enough for the balsams used in this way. In recent times Hiller has tried turpentine inhalations, but without any wonderful results. Williams and Wally experimented with carbolic acid; but Martin doubts its effect as a parasiticide against tubercle bacilli even in six per cent solution, and Renzi found that guinea pigs infected with tubercle bacilli die much quicker after carbolic inhalations. Cotteau and Chevalier proposed chlorine by inhalation in 1833, and Laennec maintained that he had seen consumptive workmen in whiteslead factories cured by the chlorine vapors. Although praised so highly its use was soon abandoned. Hiller tried bromine several years ago without success. Scuddamore tried iodine inhalations in 1834, and lately Dujardin-Beaumez and Renzi again brought them into use, but without any good results. Iodoform has also been mentioned by many as a certain means of killing the bacilli, but Vester and Cottrini have shown that it is of no value in the treatment of tuberculosis. Menthol and naphtha were crowned with no greater success. Prof Kremjanski thought he had found the panacea in aniline, but its failure is too recent to require comment.

2. *Gaseous Inhalations*. In 1799 Beddoes was of the opinion that consumption was caused by an excess of oxygen inhalation, and proposed for its cure inhalation of carbonic acid, or air which contained less oxygen, as, for example, the air in stables. Already, 1767, Read had proposed this. This method was in very general use and became quite popular.

Djadjkowski, in Russia, recommended it very highly in 1845. As late as 1880 the French Academy devoted a meeting to the question as to which stables were the most suitable. They decided in favor of cow stables, showing that they were ignorant of

the fact that cows are especially disposed to tuberculosis.

Up to 1879 the atmosphere of the stable was supposed to be beneficial to consumptives. Sulphuric acid, proposed long ago by Lorinser, has lately been recommended for inhalations by Cantanin. But Karika denies that it has any specific effect. Sulphurous acid was tried by Vallin in 1883, and he found a number of adherents. Even Dujardin-Beaumetz claimed to have had excellent results from its use. Rienzi has lately brought nitric acid before the public, although Murray recommended it in 1830; but it has been shown to be of as little service as fluoric acid, with which Charcot and Bouchard derived no effect. Nevertheless Herard, Seiler, and Garcin praise the last named very highly, and claim a disappearance of all tubercle bacilli from the sputum after the patient has passed some little time in a room to which a solution of the acid (150-330 of water) had been directed. Garcin claimed that of 100 tuberculotics 35 were cured, 41 improved, 14 remained unchanged, and only 10 died. These statistics are valuable only in cautioning us in our judgment of therapeutic effect, and render it likely that this medication will soon be added to those which have been demonstrated failures. Another method of treatment has been the inhalation of the bacterium of decomposition (cultures of the bacterium termo) which, according to Cantanin, destroy the tubercle bacilli.

3. *Exhalations.* Quite recently Bergeron proposed a treatment which consists in giving the patient, *per rectum*, a mixture of chemically pure  $\text{CO}_2$  and  $\text{H}_2\text{S}$ . It was supposed that the gas was absorbed by the intestine and eliminated by the lung, whereby the bacilli in the tissue were killed. Unfortunately Morel and Chautines found that this did not take place, although a general improvement really did occur. Moreover, Priestly and Percival had already tried this treatment before Bergeron.

4. *Subcutaneous Treatment.* The following subcutaneous treatments have been proposed:

(a) Carbolic acid (by Pilleau and Petit)

in 10 to 20 centigram doses of a one-half to one-per-cent solution daily, at the same time internal use of the same drug.

(b) Oil of eucalyptus (Roussel) in doses of 3 to 12 grams.

(c) Sulphuric acid (Dujardin-Beaumetz) in doses of 4 centigrams of a two-per-cent mixture with vaseline. Gougenheim tried a more radical method and injected a one-per-cent solution of bichloride of mercury directly into the tissues. His patients grew worse instead of better.

5. *Internal Treatment.* Countless remedies have been tried, from cucumber juice (Orabiasius) to hydrocyanic acid (Magendie), but none of them with good results. More recently iodoform and arsenic, adopted for their anti-parasitic worth, have been conspicuous failures. Creosote, which was recommended by the French in 1829, is now on trial. Guttman has recently found that creosote (1 to 2,000 of gelatine) prevents the growth of the tubercle bacilli. Unfortunately Martin contradicts him already, and says that even as strong as 1 to 1,000 is not sufficient in his hands to prevent their growth. The method of Guttman, Sommerbrodt, and Hoppmann, who give this remedy in increasing doses up to 12 grains daily, is not new, inasmuch as Eichelberg used it in 1837, giving as high as 16 drops daily, and claiming good results. Sabli and Fraenkel have shown that guaiacol can take the place of creosote, inasmuch as it has a similar effect without its inconveniences, namely, odor and bad taste. Most recently the reports on use of creosote have not been as favorable as in the beginning.

Bochmann's conclusions are by no means encouraging. He says: "All methods in use up to the present time are only relative in their value. None of them are absolute." Our principal protection is prophylaxis and atmospheric changes in the first stages. Tuberculosis is often self-limited by its termination in calcification of the tubercles.

ON THE TREATMENT OF TABES DORSALIS BY SUSPENSION.—(Prof. Charcot, *Journal de Médecine*, 1889.) According to Charcot the

success of this new method of treatment is simply astonishing, and should it prove lasting, and with exacerbations in those cases for which it is suitable, a wonderful cure has been discovered. Motchoukowsky, of Odessa, its discoverer, came upon it by accident. He was treating a tabetic patient suffering from scoliosis, whom he suspended and made wear a steel corset. When this cure had been continued for several days the patient told him that the intensity of the lancinating pains had materially lessened. At first Motchoukowsky ascribed this to the corset, but soon convinced himself that at least the principal amount of benefit was derived to the methodical suspension.

Since that time Charcot has tried it on a great many patients, and always with the same results. The suspension apparatus used in orthopedics suffices for this method; supports for the axillæ, back, occiput, and chin should be so arranged that each bears its portion in the support of the hanging body. Suspension should last one or two minutes at first; later it can be prolonged to three or four minutes. It should be repeated two or three times a week.

Charcot began the suspension treatment in October, 1888, being urged to do so by a young Russian studying medicine in Paris. The treatment has been successful in every case. Not only do the pains entirely disappear but the ataxic movements show more co-ordination. Functional disturbances, such as weakness of the bladder, existence of the Romberg symptoms, etc., are not so prominent. The mental condition of the patient impressed by the improvement is also much more cheerful and satisfactory. In spite of the fact that only a short time relatively has elapsed since the first suspension (October 22, 1888), nevertheless the instantaneous improvement that occurred, even in the worst cases after the nine hundred suspensions that have been made, is such that although it is too soon to speak of a permanent cure yet this method may be accepted as the best and most potent one for the amelioration of the the symptoms in *tubæ dorsalis*.

The writer then gives an account of a se-

ries of cases treated by this method. Among them are mentioned patients who could not walk without the assistance of friends, and who now go about readily with only a cane to assist them. Other patients are mentioned who could hardly stand erect owing to vertigo, they can now jump on and off street cars in motion without any feeling of uneasiness.

### Abstracts and Selections.

THE PREVENTION OF PUERPERAL FEVER.—Since the "germ theory" came to be so largely accepted by the profession as an established fact, the study of the septic condition known as "puerperal fever" has been greatly simplified, and its prevention has been made more than possible. Fortunately, this disease has been growing more and more rare during the last quarter of a century, and especially since the principles of Listerism have become firmly established in the minds of the profession. So-called epidemics of the disease have been rare, if indeed not entirely wanting, throughout the entire Mississippi Valley, and where any number of cases have occurred in close proximity of time and locality, a common medium of infection has been easily made apparent by careful inquiry and investigation. Atmospheric conditions are no longer considered to be important factors in the production of puerperal fever, further than that they at times conspire to lower the standard of vital activity in the economy of the subject, and so prepare a suitable soil for the reception of any infective plant that may be introduced from whatever source. The puerperal woman is frequently the subject of various febriculæ accompanied by chills and other alarming symptoms, not in any way due to septic influences in the true sense of that term, and which promptly yield to the appropriate therapy, and which are not to be confounded with the phenomena known as puerperal fever proper.

Puerperal fever or puerperal septicemia, however, does occur, and occurs too often, as it is a settled fact, in a large measure, that this is a preventable disease; that the immediate environments of the lying-in woman are the sources from which her dangers arise, and that directly in proportion as these dangers are met and removed is her immunity from the disease assured.

The large amount of decaying tissue, the denuded condition of the entire intra-uterine surface, and the gaping mouths of its sinuses, in-

cident to the puerperal state, all conspire to make this an inviting field for the planting and culture of infective germs. When once introduced into this extremely fertile soil and well established throughout the field, the progress of the disease is readily understood. The two processes by which the work of involution is accomplished, that is, sloughing and absorption, must occur in close proximity. The two flowing streams must originate at distances from each other unappreciable, and it is not difficult to understand how the infective germ finds its way into the general circulatory system. This seems plainly to be the story of the disease. The route by which the disease-producing germ may have reached the cavity of the uterus is doubtless by the way of the vaginal tract, and hence is suggestive of preventive measures to be employed. There seems at present to be no doubt entertained as to the practicability of preventing this formidable disease, which a few years ago left so many homes wifeless and motherless. The means to be employed are simple enough, but exacting in every detail. Absolute and uncompromising antiseptics is the only safeguard of the lying-in woman, and the accoucher of to-day, with present information on the subject at hand, is derelict of duty who leaves any one of the many details of antiseptics unobserved, and it may safely be predicted that, in the near future, he will not have been sustained by the profession who may have inadvertently neglected the recognized precautions to the injury of his patient.—*Journal American Medical Association.*

THE OPERATION OF PERITOMY, WITH NOTES OF TWO HUNDRED AND FIFTY CASES.—The operation of peritomy was first practiced in 1862 by Dr. Furnari, of Paris, and was afterward largely used in cases of pannus by Mr. Critchett. Some statistics upon the subject are to be found in the London Ophthalmic Hospital Reports (vol. iv, p. 182). Of late years it has fallen to some extent into disuse, and this is, in my opinion, largely due to its having been applied to lesions for which it was not properly adapted. In suitable cases it is still of the utmost value to the ophthalmic surgeon. I would especially recommend it in those troublesome cases of keratitis, ulcerative, vascular, strumous, and suppurative, which are the opprobrium of our eye wards. Prolonged courses of drops and lotions have little, if any, effect upon such cases, while peritomy rapidly brings about a subsidence of the inflammation and a quick return to the normal transparency of the cornea. The increased pressure within the cornea arising

from the separation of the strata, or by a blockage of the intercellular spaces and canals, is directly dependent upon the blood supply of the part. Now, as the cornea derives its blood supply principally from the conjunctiva, the local depletion consequent upon a division of its vessels and of the loops which surround its circumference would naturally tend to promote a healthy reaction and facilitate the absorption of those stagnant cellular elements which separate the strata, and so interfere with the refraction of the cornea. After an experience of two hundred and fifty cases, I am confident that peritomy yields unexceptionable results in the class of affections which I have indicated. It is useless to continue week after week to prescribe sedative and astringent lotions, when the case terminates too often in dense opacities which permanently impair the vision and leave behind them amblyopia, astigmatism, and a host of evils. Without pressing my opinion unduly, I would submit that the operation is worthy of a trial, and that it is to be regretted that some of our best-known text-books contain hardly any reference to so simple and effective a mode of treatment. Peritomy practiced in a large out-patient department, involving as it does the use of anesthetics, entails considerable labor upon the surgeon and his assistants. This is more than compensated for, however, when we find young patients who have suffered from all the distressing symptoms of photophobia, lachrymation and blepharospasm, coming back a few days after a thoroughly performed peritomy and interviewing their doctor, with an erect carriage and with a clearing cornea, through which day by day the light is more equally refracted. As regards the operation itself, I do not believe in partial peritomies, and I take great care to thoroughly dissect the subconjunctival tissue right up to the margin of the cornea. The after-treatment consists in the use of mild astringents and antiseptics, boracic acid (ten grains to one ounce), or yellow oxide of mercury ointment (from four to eight grains to one ounce), to encourage the absorption of opaque elements. The general constitutional condition is, of course, a separate factor which must be treated in each case upon its own merits. I make it a rule never to have recourse to peritomy until I find that milder measures are useless. If after a week's ordinary treatment the local condition is not improved, I have then no hesitation in operating. In all cases after operation I employ a compress of cotton-wool,

held in place by a bandage, shades being in my experience as often injurious as beneficial. I may say, in conclusion, that I have found peritomy useful in the chronic forms of keratitis threatening staphyloma and degeneration of the corneal structure, but not so much so as in those acute and subacute affections for which it is, in my opinion, specific.—*A. Vernon Ford, M. R. C. S., London Lancet.*

**BILIOUS ATTACKS.**—The bilious attacks occurring in neurotic individuals are very different paroxysms from those seen in habitual or occasional overfeeders. A clean tongue—often “geographical” or desquamating too freely in patches—a scanty high-colored lithatic urine, a sallow face, white motions, dilated pupils, low spirits, and absence of energy, constitute the clinical entity in many cases of bilious attacks. These are very common in neurotic children with dainty appetites, in whom to suppose that irritation and vascular engorgement of the viscera, from overfeeding, exist, would be ridiculous. A sharp purge to these patients may do more harm than good, though it is possible to set the viscera working again by such sudden means. An inadequate liver may be the cause of a toxemia, and the poison in the blood may have a selective action on the mental centers, originating lowness of spirits, melancholia; this is the view most favored by the laity, but it is often incorrect. In truth, a mutual tension between the viscera and the brain exists—reciprocity rules the realms of the human body as it does the social organism. The truth appears to be that the viscera may go wrong as the result of being undercharged with nervous energy, and they simply cease to work effectively because of defective nervous energization. The correct treatment is not a dose of castor oil, but a tablespoonful of wine at once and a tablespoonful of syrup of the hypophosphites three times every day for one week.—*Dr. Angel Money, Ibid.*

**REMARKABLE EFFECTS OF FIVE GRAINS OF ANTIPYRIN.**—Charles S. Purdon, M.B., relates the case in the *British Medical Journal* of June 15th. The patient was a man, aged fifty, suffering with sciatica. Instantly after taking the dose there was tingling and burning in the gums, which extended rapidly to the throat and nose, with sneezing, running from eyes and nose, dizziness, blindness, a pin-pricking sensation down each side of the neck, tightness of throat and dyspnea. One minute after tak-

ing, his face appeared swollen and “black” to his wife. The pricking sensation extended rapidly down the right side of chest and abdomen, and was particularly severe in right side of scrotum and right testicle, and also felt in legs and feet, particularly on the right side. Next there was a sensation as though the thoracic and abdominal organs and the right testicle were drawn upward, and he fell to the floor, trembling violently, and with cramp in right arm and hand. The physician arrived in fifteen minutes, found him sitting in a chair, with face of a dusky red color; nose, lips, and eyelids swollen beyond recognition; eyes suffused and running; breathing hurried and difficult; he was trembling all over violently, and the fingers of his right hand were clenched. Pulse scarcely perceptible. Brandy being given he felt better. He spoke in a thick, husky tone, and had dizziness and fullness in the throat. The soft palate was red and swollen, uvula enormously swollen and edematous, back of pharynx red and swollen. There was no rash. The symptoms gradually subsided, except soreness and fullness in the throat, dysphagia, huskiness, and dizziness, which continued till bed time. He had at intervals a sulphur taste. Next day he was completely recovered, except slight headache and anorexia.

**ANTIPYRINE IN CHOREA.**—Antipyrine, according to M. Jules Simon, is the medicine in chorea which has given the best results. He employs it as follows: Beginning the first day with a dose of 0 gr. 50, he increases daily by 0 gr. 50 until in children from 14 to 15 grams is taken. Usually the remedy is well borne, and only exceptionally have certain symptoms occurred, such as swelling of the face, scarlatinous eruptions and general fatigue.

These accidents are easily avoided by giving the drug in divided doses of 0 gr. 50, at regular intervals through the day, until the quantity is taken.

He advises the drug to be taken with food or dissolved in a quantity of liquid, and with these precautions has rarely had gastric complication.—*Medical Times.*

**PHENACETINE IN WHOOPING COUGH.**—Dr. Heilmann, of London, writing in the *Munchener Med. Wochenschrift*, states that he was induced to try the effect of phenacetine in whooping cough, as he had been very much disappointed with antipyrin. Although he has given children of three and four years old a few doses of fifteen grains each of phenacetine, he has never found any ill effects from its use, and the results, he says, have been uniformly satisfactory.—*London Lancet.*

# The American Practitioner and News

"NEC TENUI PENNÆ."

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D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } - - - Editors.

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## VITAL STATISTICS.

The able report on Vital Statistics, made at the May meeting of the Kentucky State Medical Society, by Dr. T. B. Greenley, of West Point, and published in full in our last issue, is attracting deserved attention, and seems likely to awaken a discussion that may, with appropriate legislation and needed reform in professional practice, leave us a "little saner" than we were before. While it can not but put us to blush, it is amusing to note the circumlocution by which the doctor at last discovered that there were no vital statistical data in the archives of the Commonwealth of Kentucky which could avail for his report. Not disposed to be foiled in the work which the Society had assigned him, Dr. Greenley fell back upon the United States Census Reports, by a careful study and ingenious use of which he was able to give us a somewhat imposing and, in a sanitary sense, flattering array of figures, with deductions and conclusions which should not pass unheeded by.

This weak point in our State economics, Dr. Greenley well says, is not due to bad legislation upon the subject, for the statute providing for the collection of vital statistics is good enough, but as the majority of our physicians

disregard it, and as there seems to be no way of forcing compliance with its requirements, it is practically a dead letter.

Now the average physician need not be told the value of well-kept vital statistics, not only to the people of the State at large but to himself. For he knows that without this help he is unable to deal with many medical problems that must present themselves to his mind for solution, viz., the ratio of births to deaths; the question of increase or decrease in the population of the State; whether immigration is to be favored or discouraged; the diseases most prevalent in the State, and their geographical distribution; the adequacy or inadequacy of our present sanitary administration, etc. In short, no physician can answer many of the most pertinent questions asked daily by his *clientèle*, or deal appropriately with any disease he may wish to make the subject of a paper for the medical society or press, without this help. The complaint is constantly made by those who read matters medical, but more especially by those who write, that our local statistical data are worthless.

The time is ripe for an awakening on this topic, and we are glad to see that Dr. Greenley's report is causing at least some of the slumberers to rub their eyes.

How is this reform to be effected is the problem of the hour. Upon this point Dr. Greenley says: "It is a small matter for each physician to keep a register of his cases of births and deaths, and at the end of the year to make a report of them to his county clerk. To be sure, the law prescribes no fee in his behalf, but probably it is taken for granted that as he does so much charity work for his *clientèle* he will not object to do a little for his State." By way of postscript he calls attention to a proposed amendment to the existing law by the Secretary of our State Board: "The Secretary of our State Board of Health shall have printed and forwarded to every physician in the State who is legally qualified to practice medicine, and also to every midwife, as far as can be ascertained, blanks, properly formed, by which annual returns of births and deaths may be made, and the same be returned to said secretary, who shall have them printed

for distribution among the profession, county clerks, members of the legislature, and officers of the State.

"For failure of compliance with the law, on the part of either officer or physician, a proper penalty should be attached."

Leaving out of the question the doctor's eulphuistic terms by which he makes a duty which we clearly owe to ourselves to look like a "work of charity for the State," several ways suggest themselves as competent to make the law of real effect; but the proposal to fix a penalty to its violation, though it may appear to the average undisciplined American as an infringement upon personal rights, is probably the only means that will secure the desired end. That such penalty is a thrust at "liberty," if not at "life and the pursuit of happiness," is decidedly the opinion of our Chicago correspondent, whose vigorous protest against such coercion makes good reading elsewhere in this issue. In favor of the penalty it might be urged that we have just such a law with reference to the reporting of cases of smallpox, and that we do not deem it a serious encroachment upon our rights or too great a tax upon our time to give the required notification even in the midst of epidemics of that disease. If, however, the idea of a penalty be distasteful, we would suggest that the State employ a canvasser whose duty it shall be to distribute and collect the necessary blanks and reports; that he take an inventory of our case records as the assessor does of our property, that thus being periodically reminded of our duty we will no more come short in the matter of vital statistics than in that of taxes. Indeed, the county assessor might profitably have this added to the other duties of his office, for the performance of which he might, with fitting propriety, be paid by a special tax levied for the purpose upon the heads of the doctors.

DR. JOHN GUIERAS, of the U. S. Marine Hospital Service, is authority for the statement that the city of Havana has had an annual epidemic of yellow fever for over one hundred years. July, August, and September are the fatal months.

## Notes and Queries.

*Editors American Practitioner and News:*

VITAL STATISTICS.—I was greatly interested in the article of Dr. Greenley in your last issue relative to the vital statistics of Kentucky. Somehow I had acquired the opinion that they did these things better in other States, and that our own commonwealth was peculiarly afflicted with laws that did not enforce themselves. While it may not be encouraging, yet it is something of consolation to know that your own legislature is but little more efficacious than ours in the quality of the law it promulgates.

For several years Illinois has had a most excellent law relating to the gathering and preservation of its vital statistics. The execution of the law has been vested in the State Board of Health, and through its efficient secretary the board has distributed proper blanks and printed forms, while an occasional letter has been sent out to those of us who would not register births, calling our attention to the omission, and pointing out the statutory pains and penalties, a fine of ten dollars for each and every failure to comply with the law. So far as I know the execution of the law has been confined to expostulations and entreaties, there has never been an instance in which an attempt was made to enforce the penalty. Notwithstanding all this effort at least one half of the births in Illinois are not registered. A great many physicians in this State regard the making out of a birth certificate as an unmitigated nuisance; it frequently necessitates an extra call to obtain the detailed information required, and is no slight addition to the already overtasked physician. To some of us who have inherited the spirit that animated a certain memorable tea party in Boston about one hundred years ago, it has seemed like a gross invasion of private rights, and intolerable, that one should be placed in the attitude of a law-breaker for every accidental infringement of this statute. Section 2, Article XXI. of our Constitution says that "no person shall be deprived of life, liberty, or *property* without due process of law;" and Section 13 of the same article provides that private property shall not

be taken or damaged for public use with out just compensation. "Every one," says Cooley (Constitutional Limitations), "has a right to demand that he be governed by general rules; and a special statute, that singles his case out as one to be regulated by a different law from that which is applied in similar cases, would not be legitimate legislation, but an arbitrary mandate, unrecognized in free government." It must be too apparent to need argument, that if these statistics are useful to the public they should be paid for out of the public treasury, and the attempt of the legislature to compel physicians to render services gratuitously to the State is an arbitrary and unwarranted invasion of private rights, contrary to our Constitution, which guarantees that private property shall not be taken for public use without just compensation. Dr. Greenley says that professional and State pride should impel every one to report these facts, and I for one am heartily in favor of correct vital statistics, but if the labor is to be put upon the profession, let it be a purely voluntary service under the auspices of the State Medical Society. Principles are greater than facts, and I for one would rather see all State sanitary work come to an end than that a single fundamental guarantee of the Constitution should be swept away.

I close with a few words of a learned judge in summing up a similar case: "These citations are sufficient to show that the police power is not without limitations, and that in its exercise the legislature must respect the great fundamental rights guaranteed by the Constitution. If this were otherwise, the power of the legislature would be practically without limitation. In the assumed exercise of the police power in the interests of the health, the welfare or the safety of the public, every right of the citizen might be invaded and every constitutional barrier swept away." (*In re Jacobs*, 98 N. Y.)

HAROLD N. MOYER, M.D.

CHICAGO, June 26, 1889.

**SIMPLE CURES.**—One thing will strike the thinking physician with surprise, and that is, however, or it might be said, the more intelligent a patient is, the more he likes to be humbugged and the more he can be deceived.

Every one has noticed how soon a patient loses faith if the medicines are not occasionally changed, or if the same line of treatment be too long persisted in, even though it be attended by improvement. As the physician relies on nature for assistance in cure, it follows that his duty is to direct the patient into the most favorable path toward recovery, and, if necessary, let nature work out the rest. Thus it happens that a prescription may be a change of climate and rest. One would think that patients able to travel would be only too glad to go when it is best for them, and give up taking drugs, but not so. How often does one hear the complaint that the physician has sent a patient to such or such a place because he did not know how to treat him, or because he wished to get rid of the patient!

The cure is so simple that the patient can not understand it. He thinks he is being properly treated when he is kept under the physician's charge at home and given medicines and made to take exercise with regularity and with disgust. It is the simplicity of the cure that the average man fails to understand. We all know that when a certain great man mentioned in Holy Writ wished to rid himself of the leprosy, how he drove off to the prophet, who was also a healer, and how he pictured to himself the whole scene of his healing, and yet when the prescription was given, or rather sent to him by a servant, to go bathe in the river Jordan seven times, the simplicity of the treatment quite upset him, and the revulsion from his idea of how he should have been treated to his prescription sent by a servant was so great that it took much persuasion to make him do as he was told and be cured.

Let any one visit the winter or summer resorts, the water cures and health resorts, and they will hear the poor doctors scolded by the very people who are improving without taking medicine. A certain amount of superstition will hang around medicine, and so long as this continues so long will physicians treat their patients accordingly.—*Maryland Med. Journal*.

**KENTUCKY STATE MEDICAL SOCIETY STANDING COMMITTEES.**—The Standing and Special Committees which are to report at the next an-

nual meeting of the Kentucky State Medical Society: Committee on Improvements in Practical Medicine, F. C. Wilson, M. D., Louisville. Committee on Improvements in Surgery, Arch'd Dixon, M. D., Henderson. Committee on Improvements in Obstetrics, G. Fayette Dunlap, M. D., Danville. Committee on Improvements in Gynecology, W. H. Wathen, M. D., Louisville. Committee on Improvements in Neurology, J. Fred. Barbour, M. D., Louisville. Committee on Improvements in Ophthalmology, Dudley S. Reynolds, M. D., Louisville. Diseases of Children, J. C. Boyle, M. D., Danville. Committee on Improvements in Laryngology, T. Hunt Stucky, M. D., Louisville. Committee on Necrology, Edward Alcorn, M. D., Hustonville. Delegates to the American Medical Association, Newport, R. I., June 25, 1889: Drs. J. A. Ouchterlony, W. O. Roberts, D. S. Reynolds, Arch'd Dixon, Fayette Dunlap, Cornelius Skinner, Jas. Lewis Howe, A. D. Price, H. Brown, B. L. Coleman, W. H. Wathen, J. M. Ray, S. G. Dabney, J. M. Mathews, T. H. Clarke, J. M. Foster, L. S. McMurtry, J. G. Carpenter, J. N. McCormack, T. B. Greenley, John G. Brooks, Pinckney Thompson, W. L. Rodman, J. Wilkes Smith, A. M. Cartledge, J. W. Gilbert, J. A. Larrabee, and Steele Bailey.

**A TEST FOR ANTIPYRIN.**—The Pharmaceutical Journal gives the following test for antipyrin: Place in a test-tube a few grains of potassium nitrate, add a little water and then excess of strong sulphuric acid, and fill up the tube with the suspected liquid. A green coloration is immediately produced if antipyrin be present. This test is delicate and reliable, and has the advantage of being specifically characteristic of antipyrin.

**AN International Congress of Therapeutics and Materia Medica** will be held in Paris, from August 1st to 5th. It is open to all medical men, chemists, and veterinary surgeons who send in their names and a fee of ten francs. There will be two Sections—one devoted to therapeutics, and the other to materia medica. Among other questions the following are set

down for discussion: (1) Antidotes and analgesic remedies. (2) The antipyretic best adapted for each species of pathogenic microbe. (3) Cardiac tonics. (4) New vegetable drugs recently introduced as therapeutic agents. (5) Uniformity of weights and measures employed in formulæ, and the utility of an international pharmacopeia.

**LIQUOR RESTRICTION.**—Druggists in license towns in Connecticut must sell only on a prescription signed by a reputable physician living in the State and known to the druggist. The prescription must give the time and place in which and the name and residence of the person for whom it is written, must specify that the liquor is for medicinal purposes, must be filled within three days of its issue, and must be filed by the druggist in a book to be open for inspection. Heavy penalties are provided for a violation of the law by physicians or druggists, and also for the individual who should obtain such a prescription on false pretences.

**THE American Lancet**, June, 1889, says: The medical profession of Michigan are almost unanimous in the desire that the Medical Department of the Michigan University should be removed to Detroit. But they are not unanimous as to the means by which this end can be accomplished. The most important obstacle is the lack of about a half a million of dollars with which to erect and put in order a plant for its use in Detroit. Possibly a couple hundred thousand dollars less might accomplish the end, but an additional quarter of a million would be far better.

**A TYPHOID COMMISSION IN INDIA.**—A commission has been appointed to inquire into the causes of the excessive prevalence of enteric fever among young European officers and soldiers. At present there appears a consensus of opinion to the effect that *acquired* contamination is the *focus et origo* of the outbreak.

The friends of Dr. Richard J. Lewis propose to perpetually endow a free bed in the Philadelphia Polyclinic Hospital in recognition of his professional eminence.

**PAINLESS EXTRACTION OF TEETH.**—Drs. Henoque and Fredel, in a communication made to the Biological Society of Paris, state that the extraction of a tooth may be rendered painless by spraying the neighborhood of the external ear with ether. The anesthesia of the trigeminus so produced extends to the dental nerves, and thus renders the production of general anesthesia needless.

**RESECTION** of the liver was first performed by Prof. Loreta, of Bologna, August 26, 1887, and a memorial tablet in commemoration of the event has just been unveiled in the Anatomical Theater there. Prof. Ruggi has repeated the operation successfully, and the patient, a woman, was exhibited at the sixth Italian Surgical Congress, which has just met in Bologna.—*Maryland Medical Journal*.

**THE NEW EDITOR OF THE "MEDICAL NEWS."** The proprietors of the Medical News, of Philadelphia, have secured the services of Dr. Hobart A. Hare as editor. Dr. Hare, in conjunction with Dr. Edward Martin, has been awarded the Warner Prize of \$500, offered by the Massachusetts General Hospital, for the best essay on the treatment of persons apparently dead from failure of respiration.

**THE JOHNSTOWN SUFFERERS.**—The Maryland Medical Journal has opened a subscription list for the relief of those physicians and their families who are sufferers from the flood. Up to June 9th, ult., \$201 had been received.

**THE AMERICAN INTERNATIONAL CONGRESS OF MEDICAL JURISPRUDENCE** held a convention in New York from June 4th to 7th. Delegates were present from England, Canada, Russia, Italy, and from nearly every State in the Union. A full report of the proceedings will be found in the Medico-Legal Journal for July.

**DR. JOHN S. BILLINGS** will receive the honorary degree of LL. D. from Oxford University.

**VIRCHOW** is said to be engaged upon a new edition of his Cellular Pathology.

**PROF. T. G. RICHARDSON** has resigned the chair of Surgery in Tulane University, New Orleans, on account of ill-health, after a continuous service in that institution of thirty-one years.

**HOSPITAL FOR MEDICAL STUDENTS AT VIENNA.**—*Le Progrès Médical* states that a society has been formed in Vienna to provide for the comfort of students who are ill. A hospital is about to be established for their accommodation.

**PROF. R. BARTHOLOW** recommends bromide of lithium to be about the best remedy for muscular rheumatism.

**A MOVEMENT** is on foot in New Orleans to secure a proper system of underground sewerage in place of the surface drainage so long in use.

**LEPROSY** question is becoming one of the questions of the day.

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### SPECIAL NOTICES.

*To Messrs. Reed & Carnick.*

*Gentlemen:* Allow me to congratulate you upon the efficient and elegant combination, Phospho-Caffein Compound, for headaches, neuralgia, insomnia, neurasthenia, and general nervous irritability. I have never found its equal. I have had the satisfaction of getting early and satisfactory results, and therefore cheerfully recommend it to the general practitioner as a valuable combination.

Very truly yours,

JOHN B. CRANDALL, M. D.,  
Health Commissioner City of Sterling,  
Pres't U. S. Ez. Board of Surgery for Pensions.  
STERLING, ILL. Jan. 19, 1889.

**DYSMENORRHEA.**—William Wiles, M. D., Snarebrook, Essex, says: I used Aletris Cordial especially in a case of severe dysmenorrhea of considerable standing. The first period that occurred after taking the Cordial was passed through with considerably less pain than usual. The patient took the medicine for a week before the menstrual period was expected, for six months. At the end of that time no difficulty or pain was experienced. So that, considering the time the patient had been suffering before, the benefit was very marked.

**THE** day of mercurials as blood alteratives is past, and vegetable alteratives have now universally taken their place. The Succus Alterans (McDade), manufactured by Eli Lilly & Co., of Indianapolis, is a rare product, and is winning laurels wherever used. Their Elixir Purgans is also valuable.—*Chicago Medical Times*.

# THE AMERICAN PRACTITIONER AND NEWS

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*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.*

## Original Articles.

### SULFONAL, THE "CHARM THAT LULLS TO SLEEP."\*

BY. J. W. IRWIN, M. D.

Sulfonal, the new hypnotic which was brought to the notice of the profession over one year ago, seems to have had sufficient trial at the hands of physicians to enable us to speak with more or less certainty as to its usefulness in that very distressing disorder of the nervous system known as insomnia.

I have been prescribing sulfonal as a hypnotic, chiefly in cases of chronic insomnia, for about one year, and as I have found the action of the drug to vary widely in different individuals, I have taken the liberty of giving the results of my own observations on its use which have not been heretofore recorded.

CASE 1. Miss Z. has not slept during the last five years without the aid of some form of hypnotic. She is of a highly nervous temperament, does not have any pain, and can not ascribe her insomnia to any known cause. I directed her to take twenty grains of sulfonal every night at 10 o'clock. The first two nights after beginning the use of the drug she did not sleep until nearly morning, when consciousness became lost in a sort of stupor or sleep that lasted about two hours, from which she awoke complaining of perceptive vertigo and dimness of vision. The dose of sulfonal was increased on the

third night. Thirty grains of the drug were given at 9 o'clock, and this dose was repeated at midnight. Soon afterward a feeling of drowsiness came on that ended in sleep six hours later. The sleep was apparently quite sound and natural, and it lasted fourteen hours. On waking and getting out of bed she was almost blind. With some difficulty she found her way to the dressing case on the opposite side of the room. She also complained of perceptive vertigo, which made walking almost impossible. The vertigo grew somewhat less three hours after getting out of bed, but vision did not improve sufficiently to enable her to read ordinary print.

Three days elapsed before she was able to walk without staggering. No more sulfonal was given, but the patient slept the greater part of the time during the next three days. On the fourth night after discontinuing the sulfonal she again became sleepless, and the drug was prescribed in doses of fifteen grains. One dose was taken at 8 o'clock in the evening, and eight hours afterward sleep came on which lasted the greater part of the day following, from which she again awoke complaining of vertigo and blindness, but in a lesser degree than before. She was then directed to take the drug at 4 P. M., and by this means sleep followed before midnight.

During the next two weeks the patient took fifteen-grain doses of sulfonal daily, which was always followed after seven or eight hours by sound sleep. When under the influence of the drug she was troubled with aphasia, and oftentimes could only utter nasal sounds indistinctly. While under the influence of the drug respiration was slowed. It did not exceed 12 per min-

\*Read at a meeting of the Louisville Medico-Chirurgical Society, June 14, 1889.

ute. The pulse became less frequent. The number of beats per minute had decreased from eighty-five before to sixty-five after the use of sulfonal. All the other functions of the body did not seem to be affected by the drug.

CASE 2. Mrs. X. has been troubled with insomnia for three or four months, which came on after giving up the use of opium, which she had been taking for ten years previously. She is very much broken down in health and has had frequent attacks of hysteria.

Twenty grains of sulfonal were given to this patient at 8 P. M., with instructions to repeat the dose at 11 o'clock if not asleep. The second dose was given at 11 o'clock, and at midnight the patient was soundly asleep. The sleep lasted ten hours, and she awoke complaining of perceptive vertigo and dimness of vision. At first she saw objects imperfectly, but two hours later vision had improved sufficiently to enable her without much inconvenience to get about the room. The second evening she took one dose of sulfonal at 7 P. M., and did not repeat it that night. This dose brought about sleep within the next three hours, from which she awoke several times before morning, but, unlike former occasions, she could easily go to sleep again. A daily dose of twenty grains of sulfonal was taken during the next four weeks, which never failed to produce sleep. Her appetite had been bad previous to the use of the drug; the sleep did not improve it and her strength failed. Vertigo was almost constant throughout the day. Objects like gauze passing before the eyes clouded her vision. The advice of an ophthalmologist was sought, fearing that some organic change in the retina had taken place.

The ophthalmologist gave the assurance that the eyes were healthy, and advised the use of spectacles.

One distressing concomitant from which she suffered during the early part of the day was aphasia. She experienced much difficulty in remembering words and occurrences, and on attempting to talk spoke chiefly in muttering nasal tones. As the

day advanced the aphasia decreased, but at no time during the use of the drug was it entirely absent. No other effect of the drug on the system was observed. The sulfonal was discontinued at the end of the fourth week, and since that time she has been sleeping every night without the aid of any form of hypnotic. It is now upward of three months since the last dose was given.

CASE 3. This case occurred in a lady much emaciated, who suffered from disordered menstruation, headache, and general debility. Her insomnia was not very severe, as she usually slept from three to four hours each night after going to bed, but on waking could not again fall asleep. She was advised to take fifteen grains of sulfonal each night at 10 o'clock; and should she awake at any time before morning, and not go to sleep again, to repeat the dose. After the second night the single dose taken at 10 P. M. usually sufficed to produce sound sleep. This dose was continued daily for two weeks, when her sleep became normal without further medication. Five months have passed since the last dose of sulfonal was given, and the insomnia has not returned.

Vertigo and dimness of vision were always noticed by the patient on getting out of bed, but after making her toilet these troubles were no longer observed.

CASE 4. A gentleman, aged seventy, who for several weeks before had been bedridden from malignant disease, and who for the relief of pain had to take from one half to one grain of the sulphate of morphia daily; the morphia having caused wakefulness, twenty grains of sulfonal were ordered to be given at 8 o'clock each night. This dose did not cause sleep, but the patient complained of a peculiar sinking sensation that lasted throughout the next day, with perceptive vertigo and difficulty in remembering words. The dose of sulfonal was repeated on the night following with similar results, differing only from those of the day previous by being more marked. The sulfonal was not repeated.

CASE 5. This was a case of arterio-scle-

rosis in a gentleman, aged eighty, that gave rise to insomnia. Sulfonal in fifteen-grain doses was prescribed for the patient, and the first dose was given at 9 P. M. As he was not asleep at midnight the dose was repeated. The patient did not sleep until nearly morning, when a sort of stupor, not a refreshing sleep, ensued.

On waking from the stupor, which lasted three or four hours, he complained of vertigo, loss of sight, and prostration, with pain in his arms and legs. I could not induce him to try sulfonal a second time.

CASE 6. A gentleman, aged sixty-four, who for fifty years has been engaged in brain work, taking but little recreation, but in every other respect has cared for his health. During the last twenty-four years he has been troubled with insomnia. He has not averaged more than three or four hours of broken sleep each night. Sulfonal was prescribed for the patient in fifteen-grain doses. The first night he took two doses, one at 7 and one at 11 o'clock. The only effect he observed from the use of the drug was that he experienced less trouble in going to sleep after waking than he had done before taking it. Slight perceptive vertigo and dimness of vision were observed the next morning on getting out of bed, but these troubles lasted only a few hours. He thought that some relief of vertigo had been obtained from the free application of cold water to his head. The second night the sulfonal was given as on the night previous, and similar results as before followed its use.

The dose of sulfonal of the previous nights not having caused sleep, on the third night the patient took thirty grains at 7, and fifteen grains at 11 o'clock. One hour later he felt a comfortable warmth all over his body, and instead of rolling and tossing on the bed as was his custom before taking sulfonal, he felt quiet and somewhat drowsy. This was his last observation for that night. He awoke the next morning at 9 o'clock, feeling that his sleep, for the first time in many years, had been very sound. On getting out of bed he had severe perceptive vertigo, and a feeling of nausea, but he did

not vomit. Dimness of vision was quite troublesome. After bathing his head and face freely in cold water his sight had improved enough to enable him to walk about, but the vertigo still caused much uncertainty of gait. He also had aphasia, and spoke chiefly in nasal tones. He observed in aphasia an old trouble that he had had eleven years before, which came on after the free use of bromides.

These phenomena lasted more or less severely for four days, during which time the dose of sulfonal had not been repeated, and then disappeared.

On the sixth day after discontinuing the sulfonal the patient expressed his willingness to try the drug again, and the same large dose was given him as before. This trial of the drug was the last made in his case, as his troubles after its use this time were much worse than before. While complaining of dimness of vision his eyes were examined by an ophthalmologist, who reported that he could not discover any pathological condition to enable him to account for the bad vision experienced by the patient. All the other functions of the body were unaffected by the use of sulfonal.

CASE 7. Insomnia in this case was due to typhoid fever in which furious delirium had occurred. Thirty-grain doses of sulfonal were given to the patient every two hours until one hundred and twenty grains of the drug were administered, and no apparent effect of any kind having been observed its use was abandoned. Six hours after the last dose had been given sleep had not followed.

I have prescribed sulfonal in several other cases of insomnia in which its effect was all that could be desired. Doses of fifteen to sixty grains were always followed by sleep in from one to eight hours after the administration of the drug. Whether or not injurious results to the nerve centers may follow the prolonged use of the drug remains yet to be fully determined.

Most of the patients who took the drug complained of perceptive vertigo on waking, which, after an hour or so, was no longer felt.

By reviewing the literature on sulfonal I find that the majority of writers on the subject agree that the new drug is worthy of a conspicuous place among the list of hypnotics. Those who have prescribed the drug the oftenest and familiarized themselves with its therapeutical use have been the strongest in its praise. It has been given in insomnia arising from almost every known cause, and good general results have been reported following its administration.

Chief among those who have had satisfactory results following the use of sulfonal, and given the results of their observations, have been Kast, Rabbas, Rosin, Oestricher, Schwalbe, Stewart, Hutchinson, Cramer, Wilson, Langgaard, Rabow, Johnson, Spillman, Otto-Dalldorf, Fraenkel, McVie, Rachel, and Garnier.

Those who have not obtained satisfactory results have been Regis and Lovegrove. The former found it unsatisfactory in cases of excitement, and its effect on the patients of the latter was discouraging. "Drowsiness with cyanosis was observed the day following its use." Salgo found it in the insomnia of paralytics "inferior to chloral and not superior to paraldehyde." Schoney gave sulfonal to a patient sixty-one years of age, who was suffering from insomnia caused by angina pectoris, and the attacks became more severe and occurred oftener. Mathes thinks the drug is not very certain in its effect, but a "useful hypnotic."

All writers agree that the hypnotic dose of the drug varies from fifteen to sixty or ninety grains. Sachs does not believe that fifteen grains of sulfonal is possessed of any hypnotic effect.

No fatal result following its use in overdoses has yet been recorded, but there are some observers who believe that forty-five grains of sulfonal is the safest maximum dose. All authors have observed the latent action of the drug, and to overcome this obstacle Kast advises that the drug be finely powdered and given in some warm liquid early in the evening.

When we come to consider the action of sulfonal from its apparent effect on the brain,

can we reasonably believe that it may be found to possess other important properties than those for the relief of which it has been generally prescribed? It may prove to be one of our most valuable remedies in controlling hyperemia of the brain and its membranes in the early stages of inflammation of those structures.

In cases of insomnia not caused by pain, I believe it is a valuable hypnotic, and by its use we find—

"Man's rich restorative, his balmy bath

That supple, lubricates, and keeps in play

The various movements of this nice machine."

LOUISVILLE.

### PELVIC INFLAMMATIONS.\*

BY A. W. JOHNSTON, M. D.

I do not know how better I can occupy the time which you have so kindly allotted me, than to spend the whole of it on just two points in regard to pelvic inflammations. First, their nature, and second, when to give them surgical interference. So much has been written on this subject that, like so many other diseases, it has been a bone of contention between the physician and surgeon, and in fact it is still a favorite race-course over which many members of both branches of the healing art are very fond of showing their paces.

You must not expect more than a mere mention of its literature, and, like many preceding writers, I can only give you the conclusions in regard to it to which quite an extensive clinical as well as pathological experience has forced me. Briefly stated, they are: that every inflammation of the thorax has its analogue in the pelvis. First and foremost we have a true croupous inflammation of the whole or any part of the pelvic structures. It runs its course like a lobar pneumonia; and though not tied so closely to the ten-day limit, still a few weeks, more or less, finds absorption setting in, and in the vast majority of cases shortly followed by complete resolution; but if in this form

\* Read before the McDowell Medical Society at its meeting in Owensboro, June 7 and 8, 1889.

of pelvic inflammation some structure have its nutrition so interfered with by the inflammatory deposit as to produce its death, at once nature begins to form a slough, and here we have the analogue of the pneumonic gangrene, which results in the simplest form of pelvic abscess.

Though this inflammatory matter may be invaded by a diffuse purulent inflammation which results in a histological condition exactly similar to some protracted forms of pneumonia, the etiology of this kind of pelvic inflammation is very much like that of pneumonia itself, and in a great many cases is traced directly to taking cold, though it too, like its cogener of the lung, is frequently traumatic in its origin. Salpingitis and an ovaritis are the same for the pelvis that bronchitis is for the thorax. An acute inflammation of these mucous structures, leaving out the presence of the air, is an exact reproduction of an acute bronchitis, not only in its course as regards time and histological changes, but also in complications, extensions, and sequelae. In the acute stages of both we have the catarrhal secretions of a mucous surface with a like proneness for extension to the ultimate limit of mucous surface, but also to a direct migration of the process through the wall of the containing organ, and an involvement of all its surrounding tissues. The vast majority of both inflammations undergo complete resolution, and leave no deleterious effects behind, but a reasonably fair percentage of both result in formation of some false band, or some new connective tissue, or some ulcerated process, which leaves a chronic inflammation behind, and thus, even in the immediate mechanics of their production, bronchiectasis and pyosalpinx are very similar if not identical.

The nature of inflammations of the ovary, histologically, is exactly that of inflammations of the lung, but from the lack of drainage its clinical picture more closely approaches that of the liver than that of the lung. The liver has its bile ducts, through which much of its pathological mucus is gotten rid of, and the fallopian tube performs the

same functions for the ovary, but neither of them are provided with sufficient passaway for any large amount of pathological product, so that the drainage of both is inadequate, and, as might be expected, the pocketing of pus is frequent, and the formation of hepatic and ovarian abscesses is by no means rare.

Pelvic peritonitis is nothing more nor less than pleurisy. Follow it through in all its forms, and from the slightest congestion of visceral or costal pleura through all its multitudinous phases of adhesions to the formation of the most virulent empyema, and you will find the pelvic peritoneum furnishes its exact counterpart. Even their etiology is identical, exposures to colds, sudden changes in vascular pressure, etc., *ad libitum*, are put down as the remote and predisposing causes for both, but undoubtedly the most common source of both is their poisoning from some foreign source.

The effect of false bands on the adjacent organs is common to both. The collapsed lung and sunken chest, with a drooped shoulder from an adherent pleurisy, is almost as common a sight on our streets as the drawn limb and halting gait caused by false bands interfering with nutrition and action of the intra-pelvic plexi and muscles. There is one strong point of difference in the life-history of a band located in either of the two cavities: one formed between the lung and the rib after it has passed over its stages of congestion and has emerged from new to old connective tissue, unless it be too extensive or placed at too bad an angle, is apt to quiet down and give little or no disturbance, except for the well known reasons for the return of pleuritic stitches; but a band in the female pelvis, no matter where placed or how situated, is liable once a month to be strung up to its highest pitch by the returning ebb of the menstrual wave. Each successive flow is liable to have its seaweed and barnacles hanging to it in the shape of some slowly dilating vessel, or gradually increasing thickening, until that which in the thorax has been a very simple affair, giving trouble only when one and

taken cold or paid the penalty for some imprudence with a pleuritic stitch, in the pelvis slowly increases until it threatens the destruction of some organ, either by its strangulation or by the shutting in of its secretions, which invites a purulent inflammation.

This point I want to make particularly strong, that it is the returning menstrual wave which causes the growth of pelvic bands, and it is the cessation of that wave at which most surgical interference in pelvic troubles aims. But before we go to the surgical side of the question there is one other condition which adds its quota to female pelvic misery, whose analogue is nowhere so strongly shown as in peri-hepatitis; this is more strongly marked in the pelvis, in what results in ovarian abscess or cirrhotic ovary. It consists in a disproportion between the amount of connective tissue and epithelium, and in some cases the epithelium is so completely overpowered and strangulated by these false bands as to quietly subside into a condition closely resembling the hob-nail liver. In others, however, this hampering of the growth and shutting in the excretions of the epithelium is just enough to cause a marked disturbance, and an ovarian abscess or a pyosalpinx is the result.

These processes, carried on until the chronic states are reached, are an exact pelvic reproduction of the various pathological conditions in the thorax known under the one head as consumption.

The history of acute tuberculous of the pelvis is the same as that of the lung, and beside tubercle there are other microbes that infest the internal generative organs; but their clinical picture is the same, and only the microscope can make the differential diagnosis. The most prominent of these is the extension of gonorrheal inflammations to the appendages, which is so well known to you all that it needs only a passing mention.

Thus, gentlemen, at the risk of being tedious, I have spent a good deal of time on these parallels, to show you that there is nothing new in pelvic inflammations, but it

contains only the two well-known forms of inflammation—croupous and catarrhal—with which pathologists have been so long thoroughly familiar, and that it is their various degenerations and logical results which furnish the abdominal surgeon the bulk of his work.

One other point I want to bring home to you before I leave this subject, and that is the folly of naming an inflammation by any one membrane in which it is supposed to be lodged. Who is there that would think of saying that in visceral pleurisy the adjoining parenchyma of the lung is not involved? Or who is there that expects that with a peripheral pneumonia there will be no interference with its pleuritic covering?

The truth is, gentlemen, that any thing like an extensive inflammation of the pelvis involves all its structures. In fact it is more like a fire on the plains which sweeps every thing before it, and it would be just as sensible to expect it to discriminate between rubbish and grain as it is to expect pelvic inflammation to confine itself either to the cellular tissue or to the peritoneum. So let me here say, once for all (as I have said frequently before), that chronic pelvic cellulitis does not exist except as a secondary result of mischief in some epithelial structure, the most common of which are the tube and ovary.

Coming to my second point, when to give these inflammations surgical relief, the rules which I will lay down are only two, first, when life is threatened, and second, when its usefulness is destroyed.

Like the surgeon of every other region, when an acute, violent inflammation results in a septicemia, we know that action must be taken at once, for it generally means that we have an acute abscess, and occasionally a gangrenous condition to deal with. In just what tissue this abscess may be located it is utterly impossible to diagnose. There is only one rough approximation which gives us any thing definite on which to hang a differential diagnosis, and that is, if the inflammatory mass seems to be fused on to the side of the uterus, it is generally a tube.

If we can appreciate a space between the fundus and the boggy mass, it is more likely to be an ovary, one which involves cellular tissue—it is impossible to differentiate. But the vast majority of all forms of acute abscesses of the pelvis so mat and mass things together as to make their enucleation quite difficult, even after the abdomen is opened, and the accurate diagnosis beforehand absolutely impossible. So that the abdominal surgeon must hold himself always ready for surprises, for to no one do they more surely come, and he is the most successful in their management who is constantly on the watch for the unexpected.

A few years ago this would have been considered heresy, but now, thanks to Mr. Tait, we know full well that all those so-called cases of chronic cellulitis are due to mischief in the tube or ovary. While his assailants were foolish enough to commit themselves to the statement that pus in these organs should be let alone, he has fully proved his case, and now there is scarcely a skeptic to the application here to the one grand surgical law: "That where ever pus be found, be it acute or chronic, it should be removed and its return prevented."

I doubt if there is one within the sound of my voice who would not agree with me in saying that all these pus cases should be operated on; and we can surely count each successful case as a life saved to our art, as the general surgeon can after an amputation for gangrene.

Sometimes, though, in cases where we expected to find pus, we find blood or serum locked up by false bands in the tube or ovary. All that can be done for such is to extirpate them, for, like long-continued hydro-thorax or hemato-thorax, if left to themselves they will sooner or later become purulent.

Now, when we approach the second rule—when life's usefulness is destroyed—we are treading on somewhat doubtful ground. When these inflammations have so swathed and bound up the tubes and ovaries as to render their function extremely difficult or almost impossible, converting their subject into a confirmed invalid, it is far better to

interfere by bringing on the change of life and returning your patient to useful citizenship.

There is, however, another form of chronic pelvic inflammation which makes your patient equally a burden on society, and that is the cirrhotic ovary, and I am sure you do both God and man service by removing these organs and returning your patient to her proper place in life.

I started with the intention of saying absolutely nothing on the subject of diagnosis, while I make it plain that I do not believe we ought ever to operate unless we can by physical examination make out a pathological condition in the pelvis. This can be determined in two ways. First of all, change in the size or position of the organs, or else some one local spot of persistent tenderness. And I wish here to state distinctly that I do not believe we ought ever to operate in these subacute cases without first endeavoring to cure them by milder means. But I am happy to say that in the vast majority of cases we will be successful.

Let me impress it upon the younger members of the profession particularly (and as I am one of them, I feel that I have a special right to speak), that it is only the exception that a laparotomy should be done for these ovarian troubles, and that the cases should be even of years' standing, and only after their resisting the most careful treatment should we think of the artificial menopause, unless we are sure that pus is present. With this ascertained, delay is murderous.

While speaking of delays, let me say that I believe one of the greatest elements in the difference of the success of the American and English laparotomists is in the time in which they get their patients. For six months I saw the whole work of one of England's best surgeons, and let me assure you most positively that in something like two hundred operations there was nothing like the terrific complications with which I am now forced to cope, and the exasperating thing about it is, to know that they could nearly all be avoided by prompt and early interference.

Burst cysts, with their accompanying violent peritonitis, tapped tumors, secondary Bright's disease accompanying an old cyst, suppurations, atrophies, and the whole list of well-advanced complications which neglected ovarian tumors are certain to produce, all go to show me that the American general practitioner is not yet up to the level of his English cousin, or else he does not study his cases quite so closely. But I am happy to say that every day I see marked evidence of improvement, and I believe the time is not far hence when the surgeon and general practitioner will walk hand in hand, and these awful complications will not be allowed to occur.

The choice time for operating on ovarian tumors (every thing else being equal) is as soon as you find it; and when our people are taught the lesson by the general practitioners that delay is death, then, and not till then, will our results reach that perfection toward which we are all so earnestly working.

DANVILLE, KY.

### OVARIAN PROLAPSE.\*

BY E. S. M'KEE, M. D.

*Definition.* A dislocation of one or both ovaries downward, and usually posteriorly also. It is true that it is often rather a symptom than a disease, but it displays certain symptoms peculiar to itself.

*Frequency.* It is much more common in multipara than in nullipara. It was found by Mundé in seventy-seven out of one hundred and forty-five, palpable out of one thousand six hundred unselected cases. From my own experience I am convinced that ovarian prolapse is far more frequent than is generally supposed. Many patients complain of a dull, sickening pain, usually referred to the left inguinal region; and in many instances, if investigation be made, it will be found due to ovarian prolapse.

*Varieties.* We may have (1) retro-lateral, into the lateral pouch of Douglas; (2) retro-uterine, in the true pouch of Douglas; (3)

intra-uterine, in the anterior or vesico-uterine pouch—very rare; (4) into the infundibulum of the inverted uterus, which is a position of the greatest rarity, one case only occurring in the practice of Prof. Simpson, of Edinburgh.

*Etiology.* Factors which lead to an increase in weight, induce traction from above, below, or pressure from above, or cause feebleness or lengthening of supports, come under this heading. Among the predisposing and exciting causes may be mentioned the conditions present in the puerperium. These favor displacement for two reasons: (1) The normal ascent of the uterus during pregnancy may stretch the ovarian ligament, and the ovary may not return to its normal size after parturition. Parturition is especially prone to this trouble if often repeated. (2) Simple congestion, resulting in enlargement of the ovary, may cause it to descend. Congestion may be an occasion and again a result of the displacement, and usually aggravates it exceedingly. Other causes are displacements of the uterus, especially the posterior ones, and prolapsus. The violent straining at stool which is sometimes occasioned by retroflexion may be the determining event of the displacement; or inflammatory conditions, due to cellulitis and to peritonitis, tumors, ascites, vesical, fecal, or gaseous distension pushing from above, the feebleness and lengthening of supports resulting from subinvolution, frequent parturition, and general debility. In rare instances acute displacements may be caused by sudden jolts or jars. We may have this displacement owing to simple increase in weight of the glands, prolonged hyperemia from sexual excess or chronic oöphoritis. A displaced ovary is at once the cause and the result of disease. A perfectly healthy ovary chained down by a retroverted uterus has its circulation at once more or less obstructed, and it then becomes the seat of chronic changes. This will more probably occur if buried in adhesions. Accompanying this dislocation some uterine tension is usually found, which we must consider as cause or effect. This can not well

\*Read at the June meeting of the Kentucky State Medical Society.

be otherwise, for the vascular relationship between the two is so close that turgidity in the one means erectility in the other. In the displacement of the ovary downward into Douglas' pouch, the most common form, the causes are more frequently gynecological than obstetrical. The pressure of the sigmoid flexure on the left side accounts for the more often occurrence on that side. Fullness of the intestine is a common cause. Robert Barnes has observed that the Douglas pouch is much deeper on the left side than the right. The left ovary is more usually prolapsed, not only because it is more subject to disease, but by reason of its greater enlargement during pregnancy. There are several influences which tend to produce this condition; chief among these is the valveless state of the left spermatic vein, which makes this vessel easily affected by an obstruction in the general circulation. The conformation of Douglas' pouch allows the left ovary to sink lower than the right, and makes it more accessible to the examining finger. Simultaneous primary dislocation of both ovaries is not common. Very thin women are more prone to this disease than fat ones. Congenital malformation may occur, and subinvolution of the broad ligaments will in some instances allow the prolapse of the ovaries when not enlarged.

*Pathology.* The enlarged ovary usually occupies an abnormal position, is often very sensitive to the touch and sometimes fixed by peritonitic adhesions, also it is often accompanied by displacements of the uterus. The usual mode of procedure is for the ovary, generally the left, to sink downward and backward, and at the same time to describe an arc toward the median line. The fallopian tube and ovarian ligament form chords. This brings the ovary behind the uterus unless the latter remains in its normal position. The ovary in its descent reaches that portion of pelvic fossa just above the level of the sacro-uterine ligament known as the retro-ovarian shelf, where it may remain. As this space on the left side is encroached upon by the rectum, the corresponding ovary is inclined to slip down still further

into the *cul-de-sac* of Douglas. When both ovaries are prolapsed, the left lies at a lower level and is more accessible to the examining finger. A perfectly healthy ovary lying in the posterior *cul-de-sac* is placed under the most favorable conditions for congestion, mechanical injury during sexual intercourse leading to subacute inflammation, which is attended by peri-oöphoritis and fixation of the gland in its abnormal position. Where due to subinvolution the ovary follows the uterus.

*Symptomatology.* Spasms of radiating, throbbing, neuralgic pains of a sickening and unnerving character, often occurring suddenly, are felt in the pelvis and surrounding parts; marked pain on walking and coition, with torturing pain on defecation, caused by the grating of hardened feces on the tender glands, especially in prolapse of the left ovary, are experienced; sickness and nausea on pressure by the examining finger similar to that felt on squeezing the testicles, dragging sensations in the groin and down the thighs, nervous symptoms with general irritability, severe hysterical symptoms and melancholia are among the indications. These are local and general, as a rule very well marked and severe. These symptoms much resemble those due to severe retroflexion of the uterus. Having associated the two conditions, ovarian prolapse and retroflexion, the symptoms may be doubly intense. Derangements of menstruation, usually menorrhagia, are sometimes present. General reflex neuralgias are often found; a general seat being in the breast, and, in fact, usually confined to the side on which the ovary is affected.

*Physical Signs.* Bimanually we feel in the true or lateral pouch of Douglas a small body or bodies exquisitely tender, and lying distinct from the uterus; on rectal examination the ovary is felt with unusual distinctness. The finger should be carried as far upward on either side of the cervix uteri as the vaginal wall will permit, and then brought down toward the sacrum, so that if the ovary is caught it will be be-

tween the examining finger and the sacrum. By this means it can be outlined by palpation and its sensitiveness determined. The degree of mobility or fixation can also be thus determined. In many instances the ovary lies so exactly central that it is impossible to tell whether it is the right or the left until the other one is found in its normal position. If the prolapse is incomplete, the ovary is generally discovered at one side of the uterus, usually a little above the junction of the body and the neck.

*Diagnosis.* As a general thing this is not difficult. It may be distinguished from enterocele by not being smooth and globular nor giving rise to gurgling on compression or resonance on percussion. It may be differentiated from epiphlocele by the absence of a peculiar soft, doughy feeling, and the irregular, ill-defined outline of the latter. A displaced ovary may be diagnosed from enlarged inguinal glands by the smaller size and simultaneous appearance of several glands in the same situation in the former case. A prolapsed ovary in Douglas' space may be distinguished from a posterior uterine displacement or tumor by recto-vaginal examination and the use of the sound. As a rule, in displacements of the ovaries there is pelvic tenesmus and pain on walking or standing, relief being obtained by the recumbent position. If the prolapsus is complete the ovary feels not unlike the fundus uteri, and gives the impression of retroflexion. The tenesmus and pain in walking is a discriminating point against inflammation of the ovaries. Differentiation from retroflexion can be made by the peculiar sensitiveness of the ovary to pressure, and by the fact that the finger can usually be passed between the uterus and the ovary. Should doubt still remain, the passage of the sound will settle the question. In case both retroflexion of the uterus and ovarian prolapse should exist, we can solve the problem by lifting the uterus by means of the sound off the ovary, which remains *in situ*. The prolapsed ovary may be mistaken for a pedunculated fibroid tumor. It may be distinguished from scybala by the ab-

sence of the mobility, softness, and comparative sensitiveness.

It is good practice to explore the posterior *cul-de-sac* while the woman is in the left lateral position, as the perineum can be pushed upward at least half an inch, and the finger reaches that additional distance along the posterior vaginal wall. Rectal examination will enable one to reach at least an inch higher up into the pelvis than by an examination per vaginam. In obscure cases this mode is of great service. If a thorough examination is not easily attained, an anesthetic will aid in clearing up the difficulty. Sensations of size conveyed by touch in the diagnosis of this trouble are deceptive. As a rule, prolapsed ovaries are larger than they appear, since only a small portion of their surface is accessible to the finger tip. In the diagnosis of mobility of the ovary we must not mistake elevation of the pelvic contents *en masse* for actual lifting of the ovary.

*Prognosis.* The question as to whether the displacement can be permanently overcome depends upon its duration, upon the condition of the ovary, whether normal or diseased, and whether there are other complications, such as adhesions, retroversion or retroflexion of the uterus. In cases of recent date, which are free from complications, permanent relief may be obtained. In many involved cases all local treatment fails. Though the life of the patient may not be directly implicated, yet the ovary after a time is liable to become congested and sensitive, and ultimately results in inflammation and changes of the organ.

*Treatment* is essentially local, and unfortunately the results are not especially brilliant. Oöphoritis being present, sexual intercourse, if permitted at all, should be carefully regulated. The bromides and ergotin exert a happy effect. If the prolapsed ovary is movable, it may in some cases be lifted out of harm's way by a pessary. Many cases can be relieved or cured by keeping the intestines empty with mercury. Should the organ be very sensitive or irritable, this condition should be removed by

the use of tampons saturated with glycerine. Great benefit is to be derived in displacements with parametric infiltrations and hyperemic conditions of the uterus and adnexa from a firmly packed column of cotton. The advantage of the cotton tamponade is that it accomplishes the same result as a pessary without exercising the same pressure. Bozeman's method of packing or columning the vagina, with the patient in the knee-chest position, offers superior advantage, since it includes the two elements pneumatic reposition and firm and continual pressure. Suppositories of iodoform, belladonna, tannin, or iodide of lead applied directly to the sensitive spot and held there by tampons afford relief. After congestion and pain are alleviated, in some cases a pessary will answer very well, but in my experience these instruments have been of little benefit. The one used has the cross-bar made broad and thick. The bulb pessary aims at the greatest degree of distension of the posterior fornix, and in this way to elevate the displaced organs. Many modifications of lever pessaries have been devised: Thomas' bulb pessary, Gehring's retroversion pessary with central depression, or one of Thomas' bulb pessaries similarly or unilaterally beveled out. The retention of a prolapsed ovary by means of a pessary is by no means so easy as the fundus uteri. The extreme mobility of the ovary renders it very liable to slip down behind the pessary, when the pain thus occasioned will soon demand the change or removal of the instrument. An air-cushion or Gariel's pessary may be introduced with advantage. These lessen the pressure, but soon lose their shape. An indentation in a hard rubber pessary, at the point where it presses on the ovary, sometimes works like a charm. Cases in which pessaries are of benefit are usually those in which there is accompanying uterine displacement. In simple ovarian prolapse they usually do more harm than good.

If the ovary has become fixed in an abnormal position as a result of peritonitis, the prospects of success from palliative

treatment are not encouraging. The persistent use of the tampon, hot water injections, local applications to the fornix, and cotton soaked in some emollient will prove of benefit. We should explain the condition of the patient to her, tell her it is a case of months not weeks, and we should patiently and persistently treat her for six months before the question of laparotomy is seriously considered. Though this routine treatment may appear very unsatisfactory, yet it is not to be despised.

For severe pain in the ovaries rectal suppositories may be used, containing cannabis Indica, belladonna, iodoform, or opium, and rectal injections of hot water as hot as can be borne. Blisters are sometimes of value applied over the ovarian region. Absolute interdiction of sexual intercourse is necessary in many cases. Rest in the recumbent position for an hour two or three times a day, is of great benefit. An abdominal brace will sometimes help by forming a sort of shelf on which the viscera may rest, and thus relieve the ovaries of a portion of their load. It also aids by narrowing the pelvic inlet and by swinging the pelvis backward.

Although pregnancy is a cause of ovarian prolapse, in my experience it has in several instances proven a cure for the disease. If pregnancy is oft repeated it is frequently an etiological factor, but if occurring at periods separated by considerable intervals it may become a remedy where ovarian prolapse exists, as when the fundus uteri thus thrust out of the pelvis it lifts the ovaries with it. When the pregnancy is completed the circumstances may be more favorable and the ovaries remain in their proper place.

The method of Dr. Henry C. Campbell, of Augusta, Ga., described in his excellent papers on posture in the treatment of pelvic troubles, relates the success attending the pneumatic reposition of the displaced organs. This is done by placing the patient in the knee-chest position and opening the vagina to allow the air to distend it; it may be used with much benefit in those cases where the ovaries are freely movable. If this be repeated at least twice daily, the

strain on the relaxed ligament and vessels is so relieved that the latter tend to recover their tone, and the patient experiences a decided amelioration of her symptoms. If she wearies of this position, after filling the vagina with air she can lie over on her side with a pillow under her hips and her shoulders low, thus keeping up the position without tiring herself. Goodell recommends that in this position the patient separate the labiæ with her fingers and allow the air to enter. Campbell uses a glass tube, which is inserted by the woman. Both of these means are unnecessary, as the ovaries will resume their proper place from the knee-chest position alone. Dr. Campbell advises that the woman kneel on the bed with her body bent forward until her chest is brought down to the surface, head turned to one side and cheek resting on the palm of the corresponding hand. Her knees should be about ten inches apart and her thighs perpendicular to the bed. If she now refrains from straining and breathes naturally, the force of gravity will do the work. Such replacements are of great value; they replace the organs, relieve congestion, give the limp ligaments a chance to shrink and keep the truant ovaries at home.

Extirpation of the ovaries, a *dernier resort* for this trouble, sometimes becomes a necessity. The vaginal operation, which at first was considered especially applicable to these cases, has not justified the hopes of its originators.

Oöphorraphy in place of oöphorectomy as a means of treatment has been highly recommended by Imlach, of Liverpool. In the virgin the ovaries slope inward, forward, and downward, and are suspended by the so-called infundibulo-pelvic ligaments or peritoneal folds of the broad ligament stretching from the pelvic brim to the infundibula of the fallopian tubes, and contain the ovarian vessels. This operation seems most applicable to cases of recent or acute prolapse. After childbirth these folds are relaxed and the ovaries are suspended by the utero-ovarian ligaments. The relax-

ation of the infundibulo-pelvic ligaments being exaggerated, the ovaries hang vertically downward, become congested and painfully prolapsed, whether the uterus is retroverted or anteverted. By this suture, which might be termed "taking a reef," the hilus of the ovaries arose to the relaxed infundibulo-pelvic ligaments near the brim, the vaginal position of the ovaries was restored, the fallopian tubes folded over them as before, and this was oöphorraphy. When retroflexion of the uterus was present, this condition was also cured by the operation. Anteversion and flexion were not rectified, though the symptoms were satisfactorily cured when dependent on prolapsed ovaries. Tait's operation for this condition consists in puckering up pieces of the broad ligament in a ligature and so shortening the ligaments in all diameters. He raised the inflamed ovary to a higher level, but failed to give the desired relief. It is questionable whether this organ will remain permanently elevated, and it is not reasonable to believe that it will be cured if actually diseased. Few operators of the present day would stop before totally extirpating the organ, which will of course sooner or later be the recourse, according to the experience or tendencies of the operator. The Weir-Mitchell rest-cure is an indirect method of treatment which is sometimes of much benefit.

Hysterorraphy affords more or less relief to patients whose ovaries are prolapsed, since the glands rise up in the pelvis as the uterus is elevated, and if deemed advisable the ovaries can be removed at the time of the operation.

Pelvic massage is of benefit if the ovary is not too sensitive. It consists in making steady upward pressure on the gland with the index or tip of the index and middle fingers for one or two minutes, varied with occasional rubbing or kneading movements, while the other hand makes counter pressure on the abdomen and down the uterus forward. This should be very carefully done, and discontinued if causing any undue pain or increase of tenderness.

Electricity, in the form of galvanism, applied two or three times a week in seances of ten or fifteen minutes, strength 15-20 milliamperes, is a valuable means of relieving the pain. The negative pole, with a large flat sponge or copper plate, is placed over the abdomen and the ball electrode positive pole in the vagina.

Schultze's method of replacing the prolapsed ovary may be undertaken if all evidences of acute inflammation have ceased and the presence of dangerous tubal disease has been excluded. This consists in etherizing the patient, placing her in the lithotomy position and introducing the forefinger of one hand into the rectum, while the other hand grasps the fundus uteri above the fundus and draws it forward. The rectal finger in contact with the imprisoned ovary seeks for an interspace between the gland and the surrounding adhesions, into which it is gradually bored until the latter becomes detached. The pressure is always made against the adhesions, not upon the ovary itself. The patient must be carefully guarded against subsequent peritonitis. Tampons or pessaries should be introduced to elevate and retain the ovary after it has been freed. This method is also applicable to cases in which the uterus is retroflexed and adherent. The ultimate results of this treatment are not well enough known as yet to allow its hearty recommendation.

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CINCINNATI, O.

## Societies.

## AMERICAN MEDICAL ASSOCIATION.

Fortieth Annual Meeting, held at Newport, R. I., June 25, 26, 27, and 28, 1889.

(CONTINUED FROM PAGE 44.)

## SECOND DAY—WEDNESDAY, JUNE 26TH.

## GENERAL SESSION.

The meeting was called to order by Dr. W. W. Dawson, the president, who called upon the Right Rev. Thomas U. Clarke, Bishop of Rhode Island, to offer prayer.

Dr. William Pepper, Provost of the University of Pennsylvania, then gave the address on General Medicine.

It consisted almost wholly of a biographical sketch of Dr. Benjamin Rush, of Philadelphia, who was born in 1745, and died in 1813. He was surgeon-general and physician-general of the Continental Army, and professor of the theory and practice of medicine in the Philadelphia Medical College. In 1775 he planned

the Philadelphia Dispensary, the first in the United States. Dr. Rush was by far the most prominent of the doctors of the Revolutionary period; so prominent, in fact, that he was to the American medical profession what Dr. Sydenham was to England. His fame rested chiefly on his great efforts in the epidemic of 1793, when he stood out beyond all his colleagues as the doctor whose practice most resembled the practice of the present day, although he treated fevers and phthisis by bleeding. His use of the lancet was compared with that of Dr. Sydenham and the present day, and the opinion given that in the earlier periods of disease it is a question if the practice of these older men was not, at times, better than the present. After considering the practice of Dr. Rush in the case of fevers, in which he advocated the use of cold water and dieting, Dr. Pepper spoke of his great abilities in other directions. In mental diseases he was a pioneer of rare sagacity, large wisdom, and enlightened humanity. His course in consumptive cases was referred to and his advanced views shown. In every way Dr. Rush was a pioneer in the field of medical practice, and the history of American medicine practically begins with, and was for a time, the history of Dr. Rush.

Surgeon A. L. Gihon, U. S. Navy, Chairman of the Rush Monument Committee, then read his report, starting with the statement that the committee could report no progress compared to their expectations, and at the present rate there was no hope even of any of the present committee ever living to see the monument. It was thought there would be no trouble in getting \$40,000, if the doctors each contributed one dollar for the purpose. After five years the committee had but one thousand, instead of the forty expected. The history of popular monuments generally agreed, however, with this, the speaker quoting the Washington, Grant, Liberty, and other monuments to show how slow the American people were in such matters compared with the Old World. He made an eloquent plea for some decisive work, and announced that the one dollar limit was dropped and that larger sums would be taken hereafter.

During the morning \$264.50 was received, one of the contributors being Dr. Early, whose family physician Dr. Rush had been. Several propositions were made to further the work of collection, and it was voted to appoint a canvasser in each county to personally solicit.

Various amendments to the Constitution were proposed, discussed, and rejected.

A resolution from the Section of State Medicine was read, stating it to be the duty of the United States and every other country to abolish sources of infection within their borders.

### THIRD DAY—THURSDAY, JUNE 27TH.

A communication was received from the Social Science Association inclosing a copy of resolutions passed by that Association demanding a more thorough training for medical students, and petitioning the State legislatures for laws against incorporation of bodies unqualified to teach medicine.

The memorial was accepted.

Dr. Hooper, of Arkansas, offered the report of the trustees of the Journal of the Association.

The report showed that the weekly circulation was four thousand six hundred and thirty-three copies, four thousand three hundred and thirty-nine of which were sent to members of the Association; the present edition was five thousand, and the Journal was free from debt.

The address in Surgery was delivered by Phineas S. Connor, M. D., of Cincinnati.

It was one of much interest, reviewing the progress of surgery in the past forty years, showing the triumphs of anesthetics, of antiseptics, of internal operative surgery, whether in the abdominal, the thoracic, or the cerebrospinal cavities, and indicating the probable conquests of the surgeon in the future—especially in regard to tuberculous and cancerous affections.

Dr. Connor brought his eloquent and hopeful address to a close with the following words:

As we survey the advances, etiological, diagnostic, and therapeutic, made in the few years just past, that are of the scientific period, and consider, even in the most hurried way, the problems that are yet awaiting solution—problems relating to nature, origin, and treat-

ment of the diseases and injuries of parts within the domain of surgery—what may we not reasonably anticipate as the future of our science and art! Accidents must occur, diseases will prevail, no matter how great the triumphs of preventive medicine. Surgical pathology is but in its infancy. Years ago it was declared that operative surgery had reached its climax. Yet since then operations have over and over again been done within the abdomen, chest, and skull, on the larynx, throat, and spinal cord, that in boldness of conception and brilliancy of execution have no parallel in the history of medicine. The end is not yet, nor will be while, the world over, there are active minds and cunning hands busied with the determination of the existence and extent of surgical affections, and ready and able to remove them, aided more and more by labors of investigators in many departments of science, general as well as medical. Year by year he who may deliver the address on Surgery will be able to report doubts removed, discoveries made, remedies employed, and operations done.

The next meeting of the Association it was decided to hold at Nashville, Tenn., the third Tuesday in May, 1890.

The report of the Nominating Committee was accepted, and the nominees were elected, as follows:

President, E. M. Moore, of Rochester, N. Y.; Vice-Presidents, J. W. Jackson, of Missouri, W. W. Kemble, of Minnesota, J. H. Warren, of Massachusetts, T. B. Evans, of Maryland; Permanent Secretary, Wm. B. Atkinson, of Philadelphia; Treasurer, R. J. Dunglison, of Philadelphia; Librarian, C. H. A. Kleinschmidt, of Washington, D. C.; Trustees of the Journal, T. O. Hooper, of Arkansas, Alonzo Garcelon, of Maine, I. N. Love, of St. Louis, W. W. Dawson, of Cincinnati. Address in Medicine, N. S. Davis, of Illinois; in Surgery, Hunter McGuire, of Richmond; in State Medicine, A. L. Carrol, of New York. Chairman of the Committee of Arrangements, W. T. Briggs, of Nashville. Assistant Secretary, G. C. Savage, of Nashville.

Dr. F. Woodbury, of Philadelphia, offered a resolution, which was adopted, recommend-

ing the alteration of our patent laws in so far as these now favor foreign manufacturers of drugs.

A resolution from the Section on State Medicine was adopted recommending uniformity in State medical legislation; that a thorough preliminary examination, three courses of lectures, and an examination by the board issuing a license be required; the license to practice be recorded in the office of the county clerk; and that the licensing board be endowed with power to revoke a license on account of immoral conduct.

Dr. Woodbury, of Philadelphia, moved that the members of the American Pharmaceutical Association be invited to seats on the platform, and that a committee be appointed to confer with the Association in reference to the creation of a Section of Pharmacy and Materia Medica in this Association, and to report on the second day of the next annual meeting.

Sir James Grant, of Ottawa, was presented, and made some brief remarks.

Officers of sections were elected as follows for the ensuing year:

Practice of Medicine—Chairman, J. H. Musser, Philadelphia; Secretary, Hugh McCall, Lapere, Mich.

Surgery and Anatomy—Chairman, B. A. Watson, Jersey City; Secretary, John B. Deaver, Philadelphia.

Obstetrics and Diseases of Women—Chairman, W. W. Potter, Buffalo; Secretary, Joseph Hoffman, Philadelphia.

State Medicine—Chairman, J. B. Hamilton, Washington; Secretary, F. S. Bascom, Utah.

Laryngology and Otology—Chairman, John O. Roe, Rochester; Secretary, Frank H. Potter, Buffalo.

Diseases of Children—Chairman, I. N. Love, St. Louis; Secretary, E. F. Booth, Mt. Vernon, N. Y.

Dermatology and Syphilography—Chairman, I. E. Atkinson, Baltimore; Secretary, W. T. Colett, Cleveland.

Oral and Dental Surgery—Chairman, J. L. Williams, Boston; Secretary, E. S. Talbot, Chicago.

There was no election in the Section of Ophthalmology.

FOURTH DAY—FRIDAY, JUNE 28TH.

The proceedings were opened with prayer by the Rev. D. A. Jordan (M. E.), after which Dr. W. H. Welch, of Baltimore, delivered the address on State Medicine.

Dr. Welch delivered what was really an exhaustive survey of the bacteriological deductions up to the present time. He concluded by warning his hearers to avoid the acceptance of exclusive dogmas or hypotheses as to the exact processes by which pernicious bacteriological agencies might make themselves actively infectious. It was not by sanitary prophylactic measures in one particular direction or another that we could hope to control the prevalence of disease, but by securing sanitary arrangements as far as possible perfect in every particular.

By resolution, the sympathy of the Association was expressed for such members of the profession as had been sufferers by the Johnstown calamity, and their dues were ordered to be remitted for the year. Votes of thanks were then passed to all those who had in any way contributed to the well-being or enjoyment of the Association in Newport. A special vote of thanks was proposed by Dr. Pancoast, of Pennsylvania, to Sir James Grant.

The chairman of the Committee on Necrology presented his annual report.

A deputation was instructed to introduce the new president, Dr. E. M. Moore, but urgent business had called him home.

The proceedings then formally closed.

In the afternoon there was an excursion upon Narragansett Bay.

## Reviews and Bibliography.

**A Manual of Diseases of the Ear.** For the Use of Students and Practitioners of Medicine. By ALBERT H. BUCK, M. D., Clinical Professor of the Diseases of the Ear in the College of Physicians and Surgeons; New York; Consulting Aural Surgeon, New York Eye and Ear Infirmary. Illustrated. Pages 420. Price, extra muslin, \$2.50. New York: Wm. Wood & Co. 1889.

This manual of ear diseases is practically a second edition of the well-known treatise by the author published in Wood's Library. As the first edition was not easily obtained, save by those who were subscribers to the Library, many will avail themselves of the opportunity to procure this work by Dr. Buck.

From a careful reading of much of the present volume, the changes made are not as numerous as we expected, and do not speak strongly of otological progress. The work is a valuable addition to otology, since the author has long been known as authority on the subject. Still, in reading the work, we see many things with which we are not able to agree. The most noticeable of these is the author's well-known objection to the syringe in the removal of impacted wax and foreign bodies. We had hoped, when he revised the original work, that the teaching there found would be changed; but he still objects to the syringe, and prefers instrumental interference. If every practitioner was advised to resort to curettes, forceps, and hooks for diseases of impacted wax and foreign bodies, the specialist would have many cases of perforated drumheads, injured canals, and impaired hearing from too vigorous instrumental interference.

The chapter on Diseases of and Operations on the Mastoid Cells is a most excellent one, and should induce every practitioner who treats such cases to procure the work and read carefully this valuable study of a very important class of cases.

A study of the small space given to a consideration of diseases of the internal ear shows that the author puts but little importance on their understanding. Indeed less attention is here paid to this portion of the ear than in any book with which I am familiar.

PROF. KARL LUDWIG.—Prof. Karl Ludwig, of Leipsic, who lately received the high distinction of the *Order pour la Merite*, is one of the most eminent physiologists living. He is the chief authority on the pressure and motion of the blood, and shares with DuBois-Reymond, Brücke, and Helmholtz the glory of having freed physiology from the theory of vital force, and of having founded the physico-chemical method. *London Lancet*.

Throughout the work the text is elucidated by the presentation of many interesting clinical reports that add to its value.

J. M. R.

**Hand-Book of the Diagnosis and Treatment of Diseases of the Throat, Nose, and Nasopharynx.** By CARL SELLER, M.D., Instructor in Laryngology and Lecturer on Diseases of the Upper Air passages in the University of Pennsylvania, Chief of the Throat Dispensary of the University Hospital, Physician-in-chief of the Union Dispensary, etc. Third edition. Philadelphia: Lea Brothers & Co. 1889.

The third edition of this popular hand book of throat diseases contains a review of the recent additions to this rapidly growing department of medicine. Within recent years more new instruments and more improved methods of treatment have been added to this specialty than to any other. They have all been of much use in stimulating a more thorough study of these diseases, and more favorable results from treatment are now attained than ever before.

The additions consist in an excellent plate showing the laryngeal image in cases of phthisis, syphilis, and tumors; a chapter on Physiology of the Voice, and a discussion of recent ideas in reference to hay fever and so-called vaso-motor coryza. The author has very wisely, and in accord with the progress of these diseases, discarded chronic pharyngeal disorders as diseases *per se*, but has accepted the ideas of Bosworth and others, that granular pharyngitis and pharyngitis secca are but symptoms of existing nasal disease. He could have also said, the same is almost invariably true of chronic laryngitis. These ideas were not accepted when first they were laid before the profession, but to-day very few treat chronic diseases of the pharynx or larynx without due attention also to the nasal trouble that will be found in almost every case.

It is quite noticeable that the author has also changed very much in his manner of dealing with nasal diseases. In the first edition treatment by means of sprays and powders was advised, and but little stress given to surgical treatment and the use of the galvanocautery and chromic acid. In this edition it

is brought abreast with the times, and new cuts appear of instruments and apparatus necessary to carry out successfully the modern treatment of throat and nose disorders.

J. M. R.

## Correspondence.

### PARIS LETTER.

[FROM A SYMPHILITIC ANATOMIST.]

Professor Alfred Fournier, the well known syphilographer, lately delivered an interesting lecture at the Hospital Saint Louis on syphilitic heredity, a most important subject, as there is a great variety of opinion as to its real source and its consequences. In seeking to define heredity, M. Fournier said that he could not accept the definition of all the dictionaries, viz., "The organic condition in virtue of which the dispositions, the manners, whether corporal or mental, physiological or morbid, pass from the parents to the children." For the learned professor heredity is not "all which passes" from ascendants to descendants, it is only in a conventional manner transmission by fecundation. "It is the contribution made to the germ, to the future embryo, of qualities special to the two generative cells (spermatozoa and ovum) at the moment when the conjunction of these two elements result from the mysterious act of fecundation." From all these facts, brought to his knowledge in the course of a large practice and which he resumes with great care, M. Fournier believes that he is able to conclude "that very certainly maternal syphilitic heredity exists, that it is undeniable. Moreover, this clinical result is in perfect harmony with that which would permit us to prejudge the question, the theoretical inductions drawn from the character itself of the malady, and the inductions drawn from anatomy. This is how things must take place, for how can we admit the idea that a malady such as syphilis is not transmissible from the mother to the fetus, while this syphilis saturates, impregnates the entire economy? Moreover, the anatomical demonstration of the reality of this transmissibility has been furnished by the recent researches of MM. Mathias Duval and Van Beneden. For these learned anatomists the parent is not, as was

formerly believed, an entanglement of the two independent circulations. The placenta is in a manner a maternal hemorrhage encysted by the fetal elements, the blood of the mother bathes as it were in the vital elements. How is it possible that in these conditions the transmission of the malady does not take place? The placenta, which has always been presented till now as an insuperable barrier, is on the contrary a very permeable filter, not only for liquids, but also for figured elements, figured contagium, microbe, bacillus, etc." This is certainly a demonstration most precise and most conclusive; but it must not be forgotten that Paolo Savi, of the University of Pisa, had shown us this permeability of the placenta in the living being "*in anima vili*" in dissecting deer offered by the Grand Duke of Tuscany, with the view of favoring the remarkable researches of the illustrious professor on the lymphatic vessels of these mammifers. This history, which dates from the year 1540, adds one more argument in favor of the theory of Professor Fournier.

In the month of February last, Professor Brown-Séquard gave an account of the experiments which he had undertaken with M. d'Arsonval, to prove that expired air contains a toxic principle. He showed that in the apparatus which he had constructed for the purpose, it could not be the carbonic acid exhaled which so rapidly killed the animals that were confined in it. But it was suggested by others that the animals may die under the influence of the putrescible matters of the urine and other solid residues. The animals kept in their cage imbibed putrid emanations. MM. Brown-Séquard and d'Arsonval have exposed animals in the same conditions to organic *débris* during three months, and the animals are doing well. The authors therefore concluded that in their experiments, if the animals died, it is because they were really poisoned by the principle so active and so toxic which the expired air in the midst of which they had to live a certain time, contained.

Dr. Emile Goubert, who received the Barbier prize for this year at the Academy of Medicine, vaunts, in the memoir for which he obtained the prize, the treatment of epilepsy

by the bromide of gold, and believes in the possible cure by this medicament. It is since 1878 that Dr. Goubert has tried this treatment. He says, that with the bromide of gold, accidents of intolerance and bromism which often follow the alkaline bromides are avoided. The average dose for an adult is eight milligrams in twenty-four hours; for a child from three to six milligrams suffice. When it is desirable to obtain a rapid effect in an adult, eight milligrams may be given at once; and, if this is not sufficient, the dose may be gradually increased according to the results obtained, but Dr. Goubert never exceeded twelve milligrams in the twenty-four hours. It appears to the author that the action of the bromide of gold is durable, as patients have been able to remain for several years, without any treatment, without the appearance of any accident or the least epileptiform manifestation. Dr. Goubert cites some examples of the good effects of the bromide of gold in migraine, whatsoever its origin. Three cases of exophthalmic goitre have been treated with complete success by this medicament.

Dr. Corneille, of Saint Marc, in his inaugural thesis affirms that he has administered distilled tar water in a great number of cases of hemorrhage. It results from his observations that this product constitutes an excellent general hemostatic, the properties of which present a great analogy with those of the "*hamamelis virginica*." The following are his conclusions: "Distilled tar-water, prepared from wood tar and the sawdust of fir wood, constitute a medicament possessing incontestable tonic astringent properties. Administered internally, it arrests with certainty and rapidity hemorrhages of congestive origin of the lungs, of the uterus, and of the kidneys. It offers the surest and promptest means of arresting hemoptysis of the first two stages of pulmonary tuberculosis. The dose is from forty to sixty grams in the twenty-four hours. The author had never observed the least accident after the employment of this medicament."

We find in the *Concours Médical* that one of the most dangerous incompatibilities of drugs consists in a mixture of laurel cherry-water with morphine. In this case an insoluble

cyanide of morphia is formed, which is precipitated in the mixture. If no attention is paid to this phenomenon, it often happens that the patient takes with the last portions of the mixture a toxic dose of morphia and hydrocyanic acid. As laurel cherry-water is recommended to preserve alkaloid solutions from microscopic vegetations which decompose them, this observation is worth noting, not only for morphia, but also for the other alkaloids. Five or six drops of hydrochloric acid per thirty grams of solution will prevent the formation of the cyanide of morphia, but if in certain cases this addition may be useful, it is not the case for solutions intended for hypodermic injections.

The *Moniteur Thérapeutique* points out the advantages of the carbolate of glycerine in cases of otitis of the middle ear and in hyperemia of the tympanum. Dr. Morpurgo, of Trieste, has employed this composition with great success. In nearly all the cases the morbid process and the suppurative otitis were arrested, he observed that since the adoption of this remedy, the diminution of the number of cases of acute suppurative otitis is very striking. The solution he employed was in the proportion of one tenth, and, notwithstanding its strength, no caustic effects have ever been observed. Dr. Meniere, of Paris, employs solutions to the strength of equal parts of carbolic acid and glycerine, and he never observed any inconvenience.

Professor Brouardel recently reported that six children died after having absorbed a mixture containing five grams of the chloride of potash. This mixture is frequently prescribed, and Dr. Bouardel thinks that many children die from the effects of the potash, while death is often attributed to the disease from which they are suffering.

PARIS, JULY 5, 1889.

## LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

From a study of the report just presented to Parliament by the committee appointed to inquire into the question of soldiers' dietary, it appears, according to Surgeon-Major Notter, that the meat ration of the British soldier is twelve ounces *avoirdupois* per diem. The

French ration is ten and a half ounces; the maximum German is little less than nine, and the Austrian a few pennyweights under ten. Italy gives her soldiers less than seven ounces of fresh meat a day; the meat ration of the Muscovite fighting man is seven ounces and a fraction, and that of the Turk nine. It is the Switzer who most nearly approaches the British ration of flesh meat, as he receives eleven ounces a day. The committee report that in nearly all cases the quality of the ration meat is good, especially at the larger military stations.

Dr. Macdonald, M. P., Coroner for North-east London, recently appeared before the select Committee on Friendly Societies to give evidence on infantile mortality and insurance. He stated that he had not yet occupied the office of coroner twelve months, although he had practiced as a medical man for many years. He had come to the conclusion, from circumstances which had come under his observation, that infantile insurance was a temptation and almost an incentive to neglect, and even to murder. Many children died from overlaying, and although some of the cases were suspicious, it was difficult to prove any thing. His office had drawn up statistics from requests for a half year, which showed that, of 46 children dying under the age of one month, 5 were insured; out of 57 dying under three months, 22 were insured; 24 children were insured out of 39 dying between the age of three and six months; from six to twelve months 36 children died, of whom 26 were insured; from one to two years 12 were insured out of 20; of children dying between the age of two and three years, 11 were insured out of 18; 16 out of 27 were insured between three and six years, and 16 out of 19 between six and ten years. He would propose, as a safeguard against neglect and crime, that the parents should be allowed to insure their children for burial only up to five years of age.

Dr. Huxford's recent experience of the effects of sulfonal seem to show that it is about as well adapted to one class of cases as another, and that the only reason for expecting a failure in any given case is the

presence of extreme pain. He is decidedly of opinion that sulfonal is a valuable medicament, but it has its limitations. In the hands of a clever practitioner it may give the most satisfactory results with very moderate doses, but in the large doses which have been recommended it may become extremely dangerous. It is easy to take, and it does not often irritate the stomach or produce ill effects. But it may fail to act as expected, and in some instances, he says, it may produce extremely disagreeable results. The dose which was at first recommended of thirty to sixty grains is, according to Dr. Rexford, far too large to commence with. It is unsafe to give more than ten grains as an initial dose, and fifteen grains he finds proves amply sufficient in the great majority of cases. The doctor has used sulfonal in a considerable variety of cases with varied success, but his cases of nervous insomnia have all yielded to it without any difficulty, and with no untoward result.

Dr. Pegrand claims to have discovered an efficient method of treating rabies. By injecting rabbits with the essence of the herb called "tansy," he produced what he calls hydrophobic intoxication, or something very similar, and with virus thus obtained he mingled ten per cent of chloral. He injected several animals which had hydrophobia with this prophylactic, and was successful in curing four out of six. The efficacy of the prophylactic will, however, have to be further tested before it supersedes in public estimation the treatment of M. Pasteur.

The statement of the Prince of Wales at the meeting to inaugurate a memorial to Father Damien, that a true leper was employed in one of the London meat markets, created profound sensation. The man has been tracked down, and in future he will no longer be compelled to follow his employment, as a fund has been subscribed to start him in some other trade. There are supposed to be not more than twenty lepers in England, and two of them—a boy and an old man, inmates of a London workhouse infirmary—were exhibited at the annual meeting of the Epidemiological Society.

Specimens were also shown by Dr. Abraham, illustrating the pathology of the disease. A discussion ensued on the increase of the malady in India, and the necessity for strict segregation. Several speakers pointed to the dangers of leprosy becoming common in this country unless precautions were taken to limit the risk of contagion. They all agreed that there was no curative treatment. Legislation to compel lepers to enter asylums was demanded by some medical men present, while others, including the chairman, Dr. Thorne, advocated a Government inquiry upon the subject.

Phthalate of morphine is now being employed with considerable success for both internal administration and for hypodermic injection. It contains nearly seventy-seven per cent of the alkaloid; and, as there is no difficulty in obtaining even a twenty-per-cent solution, it is evident that it is something like three times as soluble as the sulphate, and five times as soluble as the hydrochlorate of the organic base in question. But among its other good qualities is the fact that its solutions are less prone to decompose than are the ordinary morphine salts, and being practically amorphous, and most conveniently prepared in the "scale" form, it is not likely to be dispensed in a mistake for a quinine salt.

The fund for erecting a new hospital for women appears to be progressing favorably. The present hospital, which has been in existence over eighteen years, began in a humble way as a dispensary for women and children. It has increased rapidly, and next year, when the lease expires and they must move to new premises, the committee find that they are in a position to build a hospital. The history of the medical women's movement is very interesting, and a unique example of the perseverance and indomitable courage of one woman, for the whole movement owes its birth and progress to Mrs. Garrett-Anderson. Last year there were forty-one thousand admitted to the hospital; but its real value lies in the large number of properly qualified women doctors who have been trained there for work in India.

It is said that the wife of the Archduke Charles Theodore, of Austria, who has for some time past skillfully assisted her husband in performing the most serious of his operations, has determined to pass the examination which will place her on the list of qualified doctors, and that she is now busily engaged in reading up, with her husband as her coach, for the ordeal she will have to pass through.

Lord Randolph Churchill will shortly introduce a draft bill for the amendment of the Constitution of the Royal College of Surgeons.

LONDON, ENG., June, 1889.

### CINCINNATI CORRESPONDENCE.

Dr. P. S. Connor, who delivered the address on Surgery before the general sessions at Newport, will remain in the New England States till fall.

Dr. N. P. Dandridge, after presiding over the Section on Surgery at the American Medical Association at Newport, has gone to Nova Scotia, where he will spend the summer, returning in September.

Dr. J. T. Whittaker is spending the summer at Lake Chautauqua, as has been his custom for some time. By regularly visiting this resort he has built up a good summer practice there, and makes his summer's outing rather profitable.

Dr. W. W. Dawson is congratulated on all hands by his many friends on his being able to preside at the recent meeting of the American Medical Association, as his health had for some time threatened to prevent him from this honored duty.

A case of diabetes insipidus, with favorable termination, was the subject of a paper read before the Cincinnati Medical Society, by Dr. Philip Zenner, clinical Lecturer on Diseases of the Nervous System, Medical College of Ohio. He reported the case for the encouragement it might give in the management of similar cases, and for the valuable therapeutic suggestions it may afford. The case was that of a boy twelve years old. He passed large quantities of urine which had the appearance of dis-

tilled water. It contained neither albumen or sugar, and had a specific gravity of less than 1.001. Incontinence of urine compelled him to wear a rubber bag, and in this way the amount was measured and found to be about twenty-seven and one-half pints in twenty-four hours. The treatment consisted of electricity, antipyrine, and valerian. Antipyrine was given in seven and one-half grain doses three times a day, and powdered valerian root one-half teaspoonful three times a day. The electrical treatment consisted of the application of the galvanic current to the cervical sympathetic and to the spine, especially over the region of pain. The current used was of moderate intensity, the applications being made daily the first month, subsequently two or three times a week, each of about ten minutes' duration. The improvement in the polyuria and the condition of the bladder was exceedingly slow, while other symptoms were ameliorated more rapidly, the appetite soon returning, and the pains entirely subsiding in a month or two. The improvement, though so slow at first as to be scarcely noticeable from week to week, toward the last was very rapid. He did not suffer from thirst, and drank very little. The specific gravity of the urine finally became normal, and he could hold his urine all night. As recovery in diabetes insipidus is extremely rare, especially in cases of a year's duration, it is very reasonable to attribute the cure, in part at least, to the therapy. He thinks all three remedies had a hand in the cure.

CINCINNATI, July 13, 1889.

L. S. McKee.

### Abstracts and Selections.

HAY FEVER AND HAY ASTHMA. The return of the hay season and the prospect of there being an unusually abundant crop this year, have induced me to direct attention to hay fever, which is a subject of ever increasing interest, more especially as with advancing civilization it appears to be gradually becoming more prevalent. Sir Andrew Clark struck a true note when in the Cavendish Lecture, he emphasized the doctrine that there are three great factors concerned in the evolution of hay fever: (1) A nervous constitution or diathesis; (2) some

times inherited and sometimes acquired; (2) a local condition of irritability, involving the nervous, vascular, and cellular constituents of the affected parts, and which, when excited, disturbs the chemical, morphological, and secretory changes taking place therein; (3) external, exciting, or determining causes—that is, the agents which are capable of calling into action the irritability of the parts concerned. The first of these factors is so vague, and is so little susceptible of any direct treatment, that it will be out of place to discuss it at any length in a paper designed to be practical. As regards the third factor, there is an overwhelming weight of evidence in favor of the view that, in this country at all events, the most potent external exciting cause is the pollen of various grasses. Still there are cases in which other irritants, such as ipecacuan, dust, or even touching certain zones of the mucous membrane of the nose, will induce a train of symptoms indistinguishable from hay-fever, and, as is well known, a bright light or great heat will oftentimes start an attack in persons subject to the affection. This brings me to the consideration of the second factor, the condition of irritability of the nasal mucous membrane. In spite of what has been done in America and in Germany, the interior of the nose has received too little attention in the treatment of hay-fever. Notwithstanding the extreme views to which his enthusiasm led him, there can be no doubt that Hack did good service to medicine by pointing out that changes in the interior of the nose play a prominent rôle in the production of symptoms in other organs, as examples of which may be cited cough, migraine, supra-orbital neuralgia, giddiness, redness and swelling of the nose, etc.; but it is in hay-fever, asthma, and paroxysmal sneezing that we meet with the most pronounced examples of these reflex neuroses. The changes met with in the nose in cases of hay-fever are usually of a hypertrophic character—that is, they constitute the condition known as hypertrophic rhinitis; or they may be more limited, consisting only of a puffy swelling of the inferior turbinated bodies or of an enlargement of the posterior extremities of the same; in some cases the middle turbinated bodies are chiefly affected, or one or more polypi may be present, or there may be some abnormal condition of the septum. In a case seen last autumn, a gentleman who had been a great sufferer for many years from hay-fever, ceased to be troubled as soon as a perforation in the septum oc-

curred, thus apparently proving that the irritable zone from which the reflex started was situated on the septum. Be the local changes what they may, the paroxysm of hay-fever is invariably accompanied by swelling and engorgement of the erectile tissue, which forms so important an element of the inferior turbinated body, but which is also present in other parts of the nasal mucous membrane; and following this there is an increased secretion, which is at first purely serous, but which may become muco-purulent.

In treating a case of hay-fever, the three factors concerned in the production of the disease must be borne in mind. It will, therefore, be desirable in the first place to improve the general health of the individual as far as possible. There can be no doubt that in many cases the injudicious use of alcohol aggravates the severity of the disease. The depression and exhaustion produced by hay-fever are oftentimes so great that the patient has recourse to stimulants to counteract these effects; but though he may experience temporary relief, in the end alcohol in any quantity only aggravates the local trouble, to say nothing of the more remote evils that may result from its use. Sir Morell Mackenzie recommends one grain of valerianate of zinc with two grains of the compound assafetida pill, to be taken two or three times a day. Tincture of opium in five- to ten-minim doses, either alone or in combination with the same quantity of the tincture of belladonna, has been highly praised. I frequently order a mixture containing from ten to twenty grains of the bromide of potassium and three minims of Fowler's solution. The bromide allays the nervous erethism met with in hay-fever, while the arsenic has a tonic effect. Antipyrin, in doses of from ten to thirty grains twice a day, has recently been found very efficacious. It appears to have an anesthetic action on the sensory and secreting nerves of the nasal fossæ. As regards the second point—the removal of the patient from the exciting cause—this can be effected by sending him to the seaside or, still better, for a voyage. If neither of these plans be practicable, means must be taken to exclude the pollen, etc., by wearing goggles and having the nostrils plugged with carbolized wool when out of doors, or a silk gauze veil, doubled, may be worn over the face. But from my experience the measures detailed above are merely palliatives; they may render life in the summer months a little less miserable to

the unfortunate sufferers from hay-fever, but there is no pretense that they can effect a cure, so that with every returning June the same wearying round has to be gone through. The only plan which affords a hope of giving permanent relief is by directly treating the local condition which is the fundamental cause of hay-fever. That there is in this disease a preternatural irritability of the Schneiderian membrane, which renders it liable to respond to the effect of influences that would be entirely innocuous if applied to a healthy tissue, is, I think, pretty generally admitted, and this is the explanation of how it comes to pass, that though thousands are exposed to sources of irritation, such as the pollen of certain grasses, only an exceedingly small number suffer any inconvenience. Sir Andrew Clark, in the lecture to which I have already referred, proposes to exhaust this irritability by the application of a powerful stimulant, and for this purpose he employs a mixture of one ounce of glycerine of carbolic acid, one dram of hydrochlorate of quinine, and the one two-thousandth part of perchloride of mercury, made into a solution by the aid of heat. With this he swabs out the interior of the nose, and claims a fair measure of success for the plan. The method of treatment which has been more largely employed in America than in this country, is, however, the one which commends itself to my judgment as being at the same time based on scientific principles, and being also free from risk and attended with but comparatively little pain. I allude to the employment of the galvano-cautery. The mucous membrane of the nose must first be rendered anesthetic by the application of a twenty-per-cent solution of the hydrochlorate of cocaine, and then the thickened tissue of the inferior or middle turbinated body, as the case may be, is to be freely and deeply scored with the galvanic-caustic blade. In some cases I find it is better to use a fine point, as the deeper parts can be more thoroughly canterized with this than with the blade. The smarting after the canterization may be diminished by introducing into the nostrils wool smeared with carbolized vaseline. Even a single application will sometimes effect a great change for the better, but usually several sittings are required before complete success is attained. As regards the use of a solution of cocaine applied to the nose, the expectations which were formed of its efficacy in hay-fever when the drug was first introduced have not been realized. Though the immediate

result of the application is to produce an alleviation of the more distressing symptoms of the disease, the effect soon passes off, and the application has to be renewed if relief is to be obtained. As a result of the dilatation of the blood vessels, which is the secondary effect of cocaine, the mucous membrane increases in thickness, so that eventually the drug aggravates the evil it was meant to cure. Moreover, its sedative effect should not be forgotten, nor the risk of starting the cocaine habit ignored, so that I would join with Mr. Leonard Brown in deprecating the employment of cocaine in chronic diseases of the throat and nose. *Dr. F. De Harland Hall, London, Lancet.*

#### SUPPURATION OF THE SALIVARY GLANDS.—

An interesting and important contribution has recently been made to the pathology of the remarkable form of inflammation of the salivary glands, most commonly the parotid, which sometimes occurs in the course of specific fevers or septic inflammations in other parts. The association of parotitis with abdominal inflammatory disease is well known. The condition has generally been attributed to metastasis or pyemic infection; but this is not the conclusion arrived at by A. Henau, Ziegler's and Nowwrok's Beitrage, Bd. iv, Hft. 5, in his paper on "The Origin of Suppurative Inflammation of the Salivary Glands." He describes five cases of the disease, all but one being cases of parotitis, occurring in (1) pneumonia, (2) pyosalpinx with peritonitis, (3) phthisis with thrush, and (4) a specimen of bilateral "metastatic parotitis" in pyemia. The fifth case was one of suppuration of the submaxillary glands with perityphlitic abscesses. The histological examination of these specimens showed that the inflammation commenced in the ducts of the gland, and masses of micrococci could be seen mingled with the pus, which filled these ducts and destroyed the gland substance in the more advanced stages. Hence it was inferred that the gland was infected from the mouth, and that its involvement had nothing to do with metastasis from a primary focus elsewhere in the body. The cases are therefore comparable with purulent infiltration of other glands, for example, pyelonephritis, acne, and mammary abscess in the puerperal state. Further reasons for this view are adduced in the fact that in some cases, for example, pneumonia and typhoid, there may be no primary suppurating focus, and also in the presence of septic cases in the inflamed parotid, while the primary disease may be due to a different microbe. The disease only occurs in severe cases, and there is no essential

difference between so-called metastatic parotitis and that following on stomatitis (Virchow, Orth). Then the affection is often unilateral, and if bilateral the two glands are probably not involved to an equal extent, as is the case with a disease of systemic origin, for example, nephritis. In the less advanced degrees of inflammation the suppurating foci are distributed as in pyelo-nephritis. Moreover, it is observed that parotitis is often preceded by vomiting and by other conditions tending to make the buccal cavity impure, the most dangerous being cases of fecal vomiting; while in some cases there is a direct connection with stomatitis or thrush, even where clinically some support might be given to the metastatic doctrine. Dr. Hanau points out that in health Garré has shown the presence of some pathogenic organisms such as the staphylococcus aureus among those found in the buccal secretions, and states that these microbes increase in number in the fertile state. It is possible, too, that in septic conditions such organisms may pass out of the blood-vessels into the mouth. At any rate, in conditions where the flow of saliva is checked, there will probably be an accumulation of such organisms, and the main salivary ducts be blocked, the position of Steno's duct in favoring the involvement of the parotid gland. In an appendix the author refers to a thesis by H. Müller on the Etiology of Parotitis (Halle, 1883), where there was clear evidence of infection from the mouth. Hanau also adds a case of acute inflammation of the sublingual gland, where he could trace the course of micro-organisms through the duct walls into the surrounding lymphatic tissue.—*Ibid.*

**PATHOLOGY OF DENTAL CARIES.**—Dr. Müller, of Berlin, who has been for some years past engaged in bacteriological research, notices of which have from time to time appeared in these columns, is convinced that caries of the teeth is entirely due to parasitic action, and that it is not an inflammatory process. Messrs. Mills and Underwood, of this country, were, we believe, the first to point out that the dental tubules in caries were filled with micrococci, but Dr. Müller has studied the subject more minutely. His first series of experiments showed that the acid-forming ferment in the mouth was capable of self-reproduction, and must therefore be of organic origin—and not, as in the case of ptyalin, an unorganized ferment. Next he proved that the organisms causing caries were anaerobic; and he further obtained a pure culture, a portion of which, introduced into a tube containing a fermentable mixture, became acid in a few hours, and

in two weeks decalcified a portion of a sound tooth, the microscopical appearances being precisely those of ordinary carious dentine. Against the theory of the inflammatory origin of caries he argues that there are none of the cardinal signs of inflammation present, and the methods which would cause inflammation of other living tissues fail to produce caries. The very operation of filling teeth, he says, is an argument against the inflammatory theory. If we were to bore a hole in the soft tissues or in bone, and hammer into it a plug of gold, it would in most cases be thrown off by suppuration. Caries of dead dentine and artificial caries are perfectly analogous with caries of living dentine, and he maintains that there are no changes in the structure of dentine where the micro-organisms are not present.—*Ibid.*

**PURE CULTURE OF THE TETANUS BACILLUS OF NICOLAÏER.**—M. Kitasato, of Tokio, Japan, recalls the discovery of the tetanus bacillus by Nicolaïer, its presence in the soil, its existence in men afflicted with tetanus (Rosenbach) and claims that so far it has not been possible to obtain pure cultures of this bacillus.

A young soldier died from tetanus. In the pus of his wound the bacillus of Nicolaïer was found. Inoculation of this pus upon mice produced in the latter genuine tetanus, and the characteristic bacillus was found in them. But cultivation failed, and only mixed cultures were obtained. In examining these more closely Kitasato found by the side of Nicolaïer's bacillus three kinds of anaerobic microbes, and seven kinds of aerobic microbes; neither the former nor the latter could cause tetanus.

The tetanus bacillus is a genuine anaerobic bacillus. After having discovered that the mixed cultures obtained from the tetanus pus contained the largest number of Nicolaïer's bacilli when the oven is kept at 36°, Kitasato exposed them for some time to this temperature, and then, the cultures being in full development, he placed them for a short time in a water bath at 80°. This temperature kills the adventitious microbes, but lets the spores of the tetanus bacillus live. After this partial sterilization the plate culture was kept in a temperature of from 18° to 21°, in an atmosphere filled with hydrogen. In this way he succeeded in obtaining a pure culture of Nicolaïer's bacillus, with which he was able to produce tetanus in rats, guinea-pigs, and mice. The tetanus always begins to spread from the point of inoculation. The parts surrounding the latter are always the first to be affected with tetanus.

Nicolaïer's bacillus bears heat well. It is necessary to expose it to a temperature of 100°

for five minutes in order to kill it. A solution of phenic acid of five per cent did not destroy it at the end of ten minutes. It is remarkable that the bacilli disappeared rapidly from the blood. It seems that they develop ptomaines there. This must be established by future experiments.—*La Semaine Médicale*.

**CARDIAC SYPHILIS.**—According to Peterson, the proportion of cases of visceral syphilis in which lesions of the heart are to be found is as much as 5.5 per cent, being slightly more than those of the brain. The calculation is based on the results of one hundred and eighty-three *post-mortem* examinations in such cases, and is quoted at the close of an interesting monograph ("*Die Syphilis des Herzens*," Wien, 1889,) recently published by Dr. T. Lang, of Vienna. Dr. Lang has collected from literature the scattered records of syphilitic heart disease, and shows how each part of the organ may be the seat of lesions attributable to syphilis. Endocarditis is, he says, very rare, except in association with myocarditis. It may be parietal or valvular. The former is the more common, and is met with (at least in extra-uterine life) as a dense fibrous thickening upon the wall of the left ventricle near the apex, or at the base near the root of the aorta. This form is fairly distinctive, but valvular endocarditis of syphilitic origin is only to be distinguished by the absence of any other etiological factor; large vegetations characterize it. Besides these forms, gummata may occur on the endocardium, generally in association with peri- or myocarditis. Prominent among the symptoms is cardiac asthma, which was very marked in a case observed by the author, where also there was aphasia from cerebral embolism. Syphilitic myocarditis is less equivocal and perhaps more frequently productive of excessive interstitial growth of fibroid tissue, involving the outer wall of the ventricles mainly, less commonly the papillary muscles. It may be associated with gummata. Clinically, the disease is marked by irregularity in the rhythm and frequency of the pulse, by dyspnea, without any evidence of enlargement of the heart or of valve disease. There may be angina, suggestive of a syphilitic affection of the cardiac nerves. Many cases terminate suddenly without any previous symptoms, but where the course is more prolonged, the symptoms may be those of cardiac failure and dilatation. The diagnosis is only to be approximately made in cases with a marked syphilitic history, without evidence of alcoholism or of fatty degeneration. Prognosis is most unfavorable, but cases of "healed lesions" have been reported. Treatment consists in the

administration of the iodides, and also of cardiac tonics, as caffein and strophanthus, especially if there be much dyspnea. Syphilitic pericarditis is mostly secondary to the disease of the myocardium, and is generally partial and limited in distribution. Lastly, a rare case of congenital "syphilitic myoma" is given as an example of new growth in the heart wall attributable to syphilis. Dr. Lang's table of forty-four cases, which includes congenital as well as acquired disease, shows the preponderant number of instances between the ages of twenty-eight and thirty-seven years. He has collected some cases from the Pathological Society's Transactions (Gayley, Gould, Pasteur), as well as from the writings of Wilks and Hutchinson.—*London Lancet*.

**REPORT ON TUBERCULOSIS TO THE NEW YORK BOARD OF HEALTH.**—Doctors Prudden, Briggs, and Loomis, pathologists to the New York City Board of Health, have now presented the statement regarding the contagiousness of tuberculosis which they were requested some time ago by the board to prepare for general circulation. In it they say that it has been proved beyond a doubt that the tubercle bacillus is the cause, and the only cause, of the disease: the observations of Koch having been confirmed so often and so completely that this now constitutes one of the most absolutely demonstrated facts in medicine.

The bacilli thrown off in the discharges of human beings or animals suffering from pulmonary tuberculosis do not grow outside the body, except under artificial conditions, although they may retain their vitality and virulence for long periods of time, even when thoroughly dried. When the disease is acquired, therefore, it follows that it must result from receiving into the system the living germs that have come from some other human being or animal affected with the disease. Although the meat and milk from tuberculous animals constitute actual and important sources of danger, the disease is acquired, as a rule, through its communication from man to man.

Tuberculosis is commonly produced in the lungs by breathing air in which the living germs are suspended as dust. The material which is expectorated by persons suffering from consumption often contains these germs in enormous quantities, and after drying, in one way or another, it is very apt to become pulverized and float in the air. It has been shown experimentally that dust collected from the most varied points in hospitals, asylums, prisons, private houses, etc., where consumptive patients are present, is capable of producing tuberculosis in animals when used for their in-

oculation. It should, however, be distinctly understood that the breath of tubercular patients and the moist sputum removed in proper vessels are not elements of danger, but only the dried and pulverized sputum. If all discharges are destroyed at the time of exit from the body the greatest danger of communication from man to man would be removed.

It thus follows that tuberculosis is a distinctly preventable disease. The frequent occurrence of pulmonary tuberculosis in a family is to be explained, not on the supposition that the disease itself has been inherited, but that it has been produced after birth by transmission directly from some affected individual. When parents have the disease, and especially the mother, the children from the earliest moments of life are exposed to it under the most favorable conditions for its transmission. The measures which are suggested for the prevention of the spread of tuberculosis are: (1) The security of the public against tubercular meat and milk, attained by a system of rigid official inspection of cattle; (2) the dissemination among the people of the knowledge that any tubercular person may be a source of actual danger to his associates if the discharges from the lungs are not immediately destroyed or rendered harmless; (3) the careful disinfection of rooms and hospital wards that are occupied or have been occupied by phthisical patients.

This report reflects the position taken by Cornet as exhibited in the regulations of the Berlin Police Board.—*Boston Medical and Surgical Journal*.

**THE KOLA NUT.**—The value of the kola nut (seeds of *Sterculia acuminata*) as a dietetic and therapeutic agent has been recently tested by Surgeon R. H. Firth. These nuts are allied in composition to cocoa, coffee, and tea, but contain a relatively large amount of caffeine. The properties ordinarily assigned to kola are those of a strong tonic and stimulant to the nervous system, counteracting and removing the sense of exhaustion after fasting and fatigue; it has also been credited with having an antagonistic action to alcohol, and it has been said to purify water. From his observations Surgeon Firth concludes that kola is in no sense a food; that it increases the total urinary water, with a slight reduction of its total solids and a marked reduction of the extractive; that it has a peculiar stimulant action on the nervous system, temporarily strengthens the heart-beat, and increases the arterial tension. In times of exertion and fasting it wards off the sense of mental and physical depression and exhaustion. As a therapeutic agent in convalescence, and as an

antagonist to alcoholic sequelæ, kola has not yielded any positive results in Surgeon Firth's hands. For the purification of water it does not appear to be superior to other mucilaginous seeds, its action being purely mechanical. In this report due prominence is given to the importance of separating seeds which contain no caffeine, such as *Garcinia kola* and *Sterculia cordifolia*, as these would speedily discredit the employment of kola by the troops under conditions when it might possibly be of service. It appears that an infusion, from its astringent action, might be used for those suffering from diarrhea.—*London Lancet*.

**BROMO-MANIA.**—We commend to the serious attention of practitioners the short but very suggestive paper of Dr. George Thompson, in our issue of May 11th, on the question of Special Hospitals for the early Treatment of the Insane, and especially to the closing paragraph of the paper. There are few new remedies for which practitioners would be ready to express more gratitude than the bromides. But if Dr. Thompson is right, they are far too much used, and are even used very disastrously. In one disease—epilepsy—in which they have been thought conspicuously useful, they are capable of being much abused. Such patients, according to Dr. Thompson, are "drenched," chiefly at the out-patient departments, with bromide of potassium, till a form of bromo-mania, now well recognized in asylums, is established, and the epileptic, who fifty years ago passed easily through life, has to be put under restraint. We hope Dr. Thompson will elaborate his views a little more, even if this involves a substantiation of the charge he brings against medical men of imperfect acquaintance with mental disease. It could scarcely be otherwise, for those mentally diseased are carefully shut up in asylums, and medical students are to a large extent as carefully shut out of them. Every experienced practitioner, however, must have noticed that the bromides are not so harmless as they were thought to be, and that in some patients they produce a serious impairment and depression of nervous function.—*Ibid*.

**BERI-BERI.**—In a paper upon Beri-beri, Surgeon W. F. Thomas (*Indian Medical Gazette*, April, 1889,) states that the affection is known to be endemic in Ceylon, in certain parts of India, in Burmah, the Malayan Peninsula, Siam, Japan, Islands of the Indian Archipelago, West Coast of Africa, and in South America. Among one hundred and seventy-seven cases, no less than one hundred and twenty-eight were under thirty-five years of age, and

one hundred and fifty-two were males. Debility following ague, renal disease, and scorbutic cachexia favor its occurrence. It is influenced by changes of temperature, and in jungle districts it prevails after the rains. It is most common among natives, but Europeans suffer when dwelling in endemic districts. It is not contagious. The proximate cause in a very large number of his cases was due to the presence of *ankylostomum duodenale*; and Mr. Thomas remarks that the only appropriate treatment consists in "the expulsion of the parasites from the intestines by small doses of calomel frequently till free purging has set in, or by the administration of thymol, proper dietetic rules, and removal from the beri-beri area. Until the parasites are expelled, other treatment is of no avail." The paper deals fully with the symptoms and pathology of the affection, and a comparison is made between the acute, subacute, and the chronic forms.—*Ibid.*

VON ESMARCH ON THE DISINFECTING ACTION OF STEAM.—According to some new researches made by Von Esmarch on the action of steam as a disinfectant, it would appear that the effects in relation to the destruction of bacteria depend not so much upon the temperature as upon the degree of saturation of the steam. If there is air with it, the power of destroying organic germs is very much diminished. Thus, in experimenting on the spores of malignant pustule, Von Esmarch found that, while superheated steam which was not in a condition of saturation at a temperature of 120° C. was unable to destroy the spores in half an hour, saturated steam at 100° C. destroyed them in from five to ten minutes.—*Ibid.*

CEREBELLAR LESIONS IN EPILEPSY.—In 1869 MM. Luys and Voisin drew attention to lesions of the cerebellum and its peduncles in cases of epilepsy; they attribute to the lesions an important share in the production of the convulsive phenomena—a position, as Bourneville points out, untenable, because the cerebellar lesions never existed alone, but were always associated with cerebral disease. Anatomically, however, on the basis of a few rare necropsies, there seems to be some reason for ascribing the phenomena of procursive epilepsy—the "*Mouvements de manège*," and those of rotation—to a cerebellar lesion. The impulsive motion in a straight line or around any axis of the body, such as may be produced experimentally by section or irritation (even artificial capillary embolism), of certain parts of the brain are clearly dependent on some lesions of the brain,

and, as Jaccoud states, there may be observed in the intervals between the epileptic attacks phenomena attributable to the permanent brain lesion. Still the number of necropsies of patients suffering from procursive epilepsy or from procursive symptoms has been very limited. In some cases an atrophy and sclerosis of the cerebellar lobe has been found, and there have been great differences in weight between the right and left cerebellar and cerebral hemispheres. Adhesions of the dura mater to the brain, atrophy of the brain, thickening and edema of the pia mater, arterial anomalies, hydrocephalus, wasting of cerebral peduncles and of the pons Varolii, of the olivary bodies and pyramids, with secondary degeneration, were noted in one very interesting case. But to which of the lesions, or to how many of them, are to be attributed the procursive phenomena is still doubtful.—*Ibid.*

PROLAPSUS UTERI.—Dr. Cambela Pla, Professor of Midwifery and Gynecology in the Faculty of Medicine of Valencia, records in *La Medicina Práctica* an operation which he performed with satisfactory results on a patient of forty years of age, who suffered severely from prolapsus uteri, occasioning a feeling of heaviness and pain in the lower part of the abdomen, lumbago, dysuria, leucorrhœa, and other troubles common in this affection. The os was found between the labia, and there was a slight prolapsus of the anterior wall of the vagina; in addition, there was endocervicitis, without ectropion, but with some hypertrophy of the lower part of the cervix. The endocervicitis was treated, and a Gariol's pessary, No. 2, applied. Some five months later, after antiseptic precautions had been taken, the operation was performed. First of all the os was dilated to the extent of three millimeters by means of a laminaria tent. The needle used was tubulated, and had a curve similar to that of a uterine sound; this was introduced into the uterus, and pushed through the fundus and the uterine wall; a metallic wire was then passed through it, and the needle withdrawn, leaving the wire *in situ*; the two extremities were then secured, and the patient put to bed in a supine position, which was that in which the operation had been performed. There was subsequently some slight rise of temperature and vomiting; there was also frequent desire to micturate, which was combated by the application of ice and hypodermic injections of morphia. On the tenth day the suture was removed, and on the fourteenth day the patient was allowed to get up. Two months after the operation she had completely recovered.—*Ibid.*

# The American Practitioner and News

"NEC TENUI PENNĀ."

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D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } - - - Editors.

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## AMERICAN MEDICAL ASSOCIATION.

The fortieth annual meeting of the American Medical Association, which closed its session at Newport on the 28th ult., was in scientific worth up to the average, and in social good cheer something more.

The attendance though not large, because of the small number of delegates coming from the West, was quite sufficient to tax the hotel accommodations of the little seaport town to their utmost capacity. Good, but in few instances original, work was done in the General Sessions and the Sections, while the business proceedings were transacted smoothly and without the political maneuvering which has characterized some of the sessions in the West and South.

The address of President Dawson was able, eloquent, practical, and in accord with the times and the spirit of true Americanism. His treatment of the irrepressible question of medical education is in line with truth and common sense, however it may jar upon the esthetic sensibilities of those would-be reformers who, since its inauguration, have suffered no session of the Association to close without launching upon it some Utopian scheme for reducing the number of medical schools and raising the standard of medical education.

However desirable these ends and attainments may be, it is certain their advocates have entered the arena of controversy without due equipment, without an intelligent understanding of the situation, and with most impracticable schemes for the correction of existing evils.

We are glad to note Dr. Dawson's common-sense view of the situation, and commend the courage and vigor with which he rebukes the Utopian malcontents. But we shall let the president speak for himself. He says:

Our medical colleges now number a few more than one hundred. They may be classed as: (1) Metropolitan, those in large cities; (2) Medical colleges in less pretentious cities; (3) Medical colleges in small cities; (4) State medical colleges. For convenience, however, we may speak of them as metropolitan and provincial.

Before speaking more definitely of our medical institutions, allow me to refer for a moment to the proposition that medical schools in our country have been developed by the labors, by the self-sacrifice of the profession. As previously stated, it may be said that in this country every thing is endowed except medical colleges, schools for teaching medicine. Yes, all financial responsibilities have been and are assumed by the faculties, by men who give every hour not devoted to "earning the guinea" to college work, and in most instances without pecuniary reward. It is only recently that the wise, the generous, the favorites of fortune, and a few of the States, have conceived the idea of endowing medical schools, institutions where medicine and surgery can be cultivated without the embarrassments of financial responsibility. In the presence of such facts the work of the grumbler seems indeed ungracious.

In our metropolitan colleges every physician may feel a just pride; their graduates, most of them, will compare favorably with those educated anywhere on this earth.

The accomplished Dr. Senn, after a liberal experience with foreign schools, said: "There is no question in my mind that the average American student learns more in one month than the average German student in three. He learns more, not because he has better teach-

ers or better facilities, but he makes better use of his time. I am satisfied that in our last graduating class I had at least a dozen students who, after studying three years, would pass a brilliant examination in any English or German university. They would have felt at home, even in a dress coat, in Volkmann's Klinik passing their final examination."

Provincial schools do praiseworthy, yes, thorough work in training young men, not only in rudimentary branches, but in practical clinical studies. Many supplement these by hospital attendance in the great cities and by post-graduate courses. It is gratifying to know that these organizations are being established in all of the great medical centers.

The advance in medical education is again most distinctly pronounced by a remark recently made by one of our distinguished Fellows, an American-bred physician, of whose fame we are all justly proud. In a conversation Dr. Battey said: "When I began the practice, thirty years ago, there was scarcely a graduate within fifty miles of my residence; now, however, there is hardly a practitioner in the same territory who is not a graduate, and year after year a portion of our young men leave home to avail themselves of clinical advantages, to attend post-graduate instruction." Could any thing show more forcibly the conservative and steady growth of medical culture?

*Have medical colleges increased too rapidly?* Should they be established in small cities where clinical material is limited, where it must be comparatively scarce? Before answering this, it may be well to reflect upon the proposition that, in our own country as well as elsewhere, great achievements have often been made in the provinces and not always under the shadow of the universities. One of the great operations waited for years for a metropolitan disciple—one to take it up—and that, too, long after the provinces at home and abroad had demonstrated its vital utility, its claim upon the scientific and skillful surgery.

As our population increased from three to sixty-five millions, the demands for medical men were great—colleges increased necessa-

rily. Have they multiplied in undue proportion?

In answering this question I beg to quote from my beloved master, Samuel D. Gross, to whom this question had been put. After mature deliberation, he said, "Our colleges are not annually graduating one physician for each county in the States and Territories. This is certainly not exceeding the demand." A considerable proportion of those who graduate never enter the ranks—death and desertion claim a large share. It would simply be impossible for the metropolitan schools to graduate all required.

For the introduction of young gentlemen into the profession there is a mutual responsibility between teachers and preceptors. In very truth it may be said that colleges do their duty, their very best, with the students furnished by the preceptors. Give us liberally-educated young gentlemen, and we will furnish graduates worthy of the degree. Medical colleges, however, do not make the physician. They merely furnish the foundation work; the individual must do the balance. In no place is evolution so marked—the fittest will and should survive.

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#### LOUISVILLE SURGICAL SOCIETY.

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At the annual meeting of this Society, on the 13th instant, Dr. D. W. Yandell was re-elected to the presidency, Dr. J. M. Mathews to the vice presidency, and Dr. E. R. Palmer to the secretaryship.

This Society closes its second year with a record of exceptionally interesting scientific work, as our readers well know. The American Practitioner and News will continue to publish these valuable proceedings.

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DR. FERDINAND HUELPE, of Wiesbaden, has been appointed Professor of Hygiene at Prague. He is the sixth of Robert Koch's pupils who has been appointed to a professorship. The other five are Galky, of Giessen, Wollfing, of Gottingen, Loefler, of Grunswald, Goertner, of Jena, and Bernhard Fischer, of Kiel.

## Notes and Queries.

*Editors American Practitioner and News:*

VITAL STATISTICS—A REJOINDER.—In your editorial in the last issue you state that the penalty provided for not registering certain vital statistics is, in the opinion of your Chicago correspondent, a thrust at "liberty," if not at "life and the pursuit of happiness." The tenor of my first letter was, I think, that the thrust was at *property*, as it is not contended for a moment that personal rights are invaded by a law such as that proposed.

The chief contention is that the legislature has no more right to compel me to make out a birth certificate for the benefit of the public than it has to order my neighbor to dig a ditch without compensation. In either case it is taking the property (that is, labor) of a private individual for the benefit of the whole community without compensation. If these statistics are valuable to the State, let the public pay for them and not attempt to force persons into unwilling service by means of fines and penalties. If the principle is once admitted, that it is the duty of a physician to furnish vital statistics without compensation, where is a proper line to be drawn? Now it is asked that we make out a detailed account of each accouchement. Shortly, will it not be required to report typhoid fever cases, with results? Would not valuable data be acquired by a compulsory registration of all venereal diseases? If a vicious principle is once adopted it may be carried any length, and we shall soon be compelled to keep a well-bound book in which all cases are recorded, and which shall be open at all times to the inspection of the commissioner, resident house-holders, health officer, etc. The failure to comply with this regulation shall be deemed a felony, and punishable by imprisonment in the penitentiary.

It may be thought that this picture is overdrawn, but it is not, for the making out of a birth certificate is not one whit different from any other business that concerns the private relation of physician and client. What is just and right in one case, can not be wrong and inequitable under similar conditions in another.

In your editorial you say that you have just

such a law in reference to the reporting of small-pox cases. Allow me to suggest that there is a slight difference. Under the police power the legislature have the right to require services of individuals that conserve the lives or property of others. A person may conceal a fire upon his premises, and in that way place the lives and property of adjacent property-owners in jeopardy. Under the police power laws could be passed compelling individuals to report fires. Such a law would be constitutional, because it would tend to conserve the lives and property of others. So, in a case of smallpox, it is a menace to the lives of others, and under the police power a report can and ought to be required. No one has a moral or legal right to withhold information and endanger the lives of others.

The only argument that can be advanced for the compulsory registration of births is that it furnishes some needful information to the public. In Dr. Greenley's article, he enumerates among the benefits to be derived from correct vital statistics, that they are essential to judge of the growth of population, the health of the country, and the nature and character of its diseases. Colonists wish to enter a country, and naturally they seek some information concerning the public health. In no place does he charge that the failure to report births in anyway jeopardizes the people's lives or health.

It seems to me that many of our enthusiastic sanitarians are going a little too far in some of their requirements, and there will come the inevitable reaction, to the great detriment of our public sanitary service. The subject has the widest general relations, medical practice acts, police powers of sanitarians, quarantine, and other subjects all come within the scope of these constitutional limitations. "Thus far shalt thou go, and no farther." The sanitary official may interfere to protect the health and lives of the community, may require all needful service and information to this end, but the attempt to signal out a special class to bear burdens not imposed upon others, or to convert the members of a great profession into a bureau of information, is, under our form of government, foredoomed to failure.

CHICAGO, July 12, 1889.

HAROLD N. MOYER.

*Editors American Practitioner and News:*

**HYPERSECRETION OF URINE IN DIARRHEA; CASE.**—A nursing infant was brought to my office, July 1st, suffering from a severe attack of summer diarrhea, with frequent green discharges from bowels. I ordered three-grain doses of lactopeptine. Heard no more of the case till July 15th, when I saw the child again, and its mother assured me that its bowels were in a healthy condition; its appetite was good, but it had continued fever, very restless, and was becoming rapidly emaciated. Kidneys very active. In fact the polyuria was the cause of the child's being brought to my office the second time. Now, what I wish to suggest is, that a child may be suffering from "summer complaint" and yet have natural actions from the bowels. But in such cases we always find that a very great amount of urine is discharged. Now, is it not the case that the hypersecretion of urine is caused from malassimilation? The food of infants is liquid, and, while its water is chiefly eliminated by the kidneys, may not the sugars and albumens in the blood form crude products which cause a superabundance of urine, just as indigestion causes too frequent actions from the bowels? I have treated a number of cases of this character, and would be glad to hear from the profession.

F. M. SMITH, M. D.

CLOVERPORT, KY.

**A NEGLECTED GENIUS.**—The Texas Health Journal says: The indifference of some to the current medical and sanitary literature of the age is passingly strange. It is a problem hard to solve. These reflections result from a recent incident incomprehensible in its immensity. A subscriber returned this journal with the following soul-stirring revelation: "Stop the Medical Health—am over red now—all I knead is treatment—got to big a library anyhow—besides I already take the theripudic gazet—didnt subscribe for your journal know how. — M. D." We are confident this man is over "red"—but just how "red" we have no means of ascertaining—and that he thoroughly "kneads" his treatment—blue mass especially. Being already overstocked with the "theripudic gazet" and "to big a library," he "dident" "knead" the Journal "know how"—therefore

we feel indisposed to press our claims, lest the gentleman become overwhelmed with pure "medical health." Regretfully we leave him to the peaceful enjoyment of his erudition and peculiar vernacular. So long as such men are intrusted with human lives the cause of a high mortality in some localities may, with some degree of certainty, be surmised.

**HEALTH OF JOHNSTOWN.**—The representatives at Johnstown of the State Board of Health issued, on June 12th, a bulletin stating that there is a favorable condition as regards the health of the town. Only one case of diphtheria and two of pneumonia are reported in the whole devastated region, and not a single case of typhoid fever. There is almost a phenomenal absence of sickness. Not a single case of dangerous illness, it is said, is known to the board. The water supply, which is brought in iron pipes from mountain springs four and five miles distant, has been inspected by Dr. P. M. Carrington, of the United States Marine Hospital Service, and Dr. E. O. Probst, Secretary of the Ohio State Board of Health, and is pronounced as pure as before the flood. There is no general pollution of the atmosphere by effluvia dangerous to health. The numerous large fires for burning *débris* keep the air in rapid motion, while the comparatively low temperature which has prevailed has contributed to its purity.—*Medical and Surgical Reporter.*

**HONOR TO JOHN S. BILLINGS.**—In referring to the recent honor conferred by the University of Oxford upon this great man, the British Medical Journal says:

Dr. Billings has also done great service to the whole of the medical profession by his *Index Medicus*, begun in 1879, and still in regular publication. He is now preparing a large dictionary of medical terms, in two volumes, which is to appear speedily.

With such a record it is not to be wondered that the University of Oxford, wherein all that Dr. Billings has done is well known to Sir Henry Acland, should have deemed him worthy of the high honor of its D. C. L., thus adding his name to those of Owen, Alison, Brodie, Milne Edwards, Van der Haven, Christison,

Stokes, Jenner, Gross, Paget, Lister, Allen Thompson, William Farr, Simon, and others, to whom she has given in the last few years her highest degree. Besides this honor, he already holds the honorary degrees of LL. D., Harvard, LL. D., Edinburgh, and M. D., Munich, and he is a member of the National Academy of Sciences in America, which may be in many respects compared to our Royal Society.

How various are the ways by which scientific medicine is being advanced is plain enough to our readers. It is pleasant to think that the United States are advancing along the whole line of knowledge. It is of no small moment that Washington, but lately only a political capital, is becoming a center of scientific biological effort, through the rapidly expanding National Museum, and the labors of Dr. Billings in the War Office. The probable effects can not easily be overestimated. The problem of the future of the United States is one of the most interesting as well as the newest in the history of the human family. The modern appliances for material growth there seen have never in history been so rapidly developed, and we are glad that a firm grasp is likely to be taken by our American brethren of all the circumstances that affect the progress of a scientific, curative, and preventive medicine.

#### DR. BROWN-SEQUARD'S HYPODERMIC FLUID.

The extraordinary statements made by Professor Brown-Séquard as to the efficiency of hypodermic injections of fluid expressed from the testicles of young animals in senile debility have been, to a certain extent, confirmed by M. Variot, who made a communication to the Société de Biologie on June 29th. The patients chosen were debilitated men, aged fifty-four, fifty-six, and sixty-eight years respectively, and they were not informed of the nature of the treatment adopted. In all three cases the injections were followed by general nervous excitement, increased muscular power, and stimulation and regulation of digestion. M. Brown-Séquard said that M. Variot's observations disposed of the objection that the results he had observed in himself were due to "suggestion."—*British Medical Journal*.

THEODOR SCHWANN.—A memorial tablet has lately been affixed to the house at Neuss, in Rhenish Prussia, in which Theodor Schwann, the originator of the cell theory, was born. His father was a bookseller there, and a devout Roman Catholic. The naturalist himself was also characterized by religious zeal. Before publishing his epoch-making work on the cell, he wrote to the Archbishop of Malines, to whose diocese his native place belonged, stating his new theory, and begging his opinion whether it was at variance with the doctrines of the Catholic Church. The prelate found nothing heretical in it. It was published in Berlin in 1839, under the title, "Microscopic Investigations Regarding the Harmony in the Structure and Growth of Animals and Plants." Schwann was at that time assistant in the Berlin Anatomical Museum.—*London Lancet*.

QUEEN VICTORIA has appointed Dr. Richard Quain, the well-known author of "Quain's Dictionary of Medicine," one of her physicians extraordinary.

A DISPATCH from Bombay, India, says that a brigadier-general of the British army, stationed in Madras, has been attacked with leprosy.

#### SPECIAL NOTICE.

Messrs. Reed & Carnrick:

Gentlemen—In recognition of the courtesy shown us by your invitation to visit your laboratory at Goshen, and personally observe the several successive steps in the process of preparing your *Soluble Food*, we desire to express our thanks. We were very forcibly impressed with the precaution exercised in obtaining practically sterilized and partly digested milk, and the absolute cleanliness observed throughout the entire process. We unhesitatingly indorse your *Soluble Food*, and shall continue prescribing it for our babies. Edward Molitor, M. D., Somonauk, Ill.; J. Gill. Allan, M. D., Shelbyville, Ky.; J. D. Herrmann, M. D., Eastman, Ga.; S. T. Turner, M. D., El Paso, Tex.; J. I. McConnell, M. D., Chattanooga, Tenn.; J. C. B. Justice, M. D., Asheville, N. C.; B. Z. Henslee, M. D., Dickson, Tenn.; W. G. Ferguson, M. D., Hughesville, Mo.; J. H. McDuffee, M. D., Keyser, N. C.; W. H. Hudson, M. D., La Fayette, Ala.—*From New York Polyclinic School*.

NEW YORK CITY, November 9, 1888.

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNĀ."

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*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we need downright facts at present more than any thing else.—RUSKIN.*

## Original Articles.

### COCAINE IN EYE, EAR, AND THROAT PRACTICE.\*

BY S. G. DABNEY, M. D.

*Professor of Physiology and Clinical Lectures on Diseases of Eye, Ear, and Throat, Hospital College of Medicine, Visiting Surgeon to Eye and Ear Department of Louisville City Hospital.*

It is certainly not too much to say that the province in which cocaine finds its most perfect application is the area of distribution of the fifth pair of cranial nerves. I wish to present briefly a few points in regard to its use in this region. The strength generally employed is two grains to the dram, or approximately four per cent. For operations on the eye it is best to instil a few drops of this solution about ten minutes before operating, and repeat in three or four minutes. Among the slight ocular operations for which cocaine, so applied, is of the greatest service is the extraction of foreign bodies from the cornea; a drop or two of cocaine renders this otherwise acutely painful procedure altogether painless. The slitting up of the canaliculus for obstructed tear-passages is made much easier by the instillation of cocaine; the injection of the same into the lachrymal sac, and, if possible, through the duct, renders probing much less painful and sometimes allows the passage of a larger instrument. For this purpose I have also used a salve of cocaine and vaseline applied on the probe, but have found the previous injection of a solution

more satisfactory. Cocaine renders iridectomy an almost painless procedure; the clipping of the iris does, however, still cause some pain. In the extraction or needling of cataract, local is in almost every case superior to general anesthesia. Among the disadvantages of chloroform or ether may be mentioned the vomiting which is apt to follow their administration, and its liability to cause prolapse of iris or vitreous humor, or other disaster to the eye. For ectropion I have within the last two years operated several times according to a method recommended by Dr. Green, of St. Louis, in the American Journal of Ophthalmology; as this condition is due to a cicatricial contraction of the tarsal cartilage, causing incurving of the lid, the simplest procedure would seem to be to cut through the cartilage longitudinally from the mucous surface, and then for a short time to keep apart the surfaces of the cut so made by stitches passed under the skin of the lid and united over a little ball of cotton so as to thoroughly evert the lashes.

This is the course recommended by Dr. Green, and one I have found very satisfactory. Preparatory to this operation the lid should be turned out and a four-per cent or stronger solution of cocaine applied, soaked in a pledget of cotton. There is apt to be quite profuse bleeding, and the hemostatic properties of cocaine come into excellent service. I have heard little in the last year or two of the tendency of cocaine to increase secondary hemorrhage. I have not observed such an effect myself. For the removal of chalazia, if the incision is to be through the skin, a few drops of a four-per cent solution should be injected hypodermically. Here the lid forceps of Desmarres

\*Read at the meeting of the McDowell Medical Society, in Owensboro, June 7, 1889.

or Knapp serve admirably, not only to restrain bleeding, but to prevent the diffusion of cocaine through the loose tissue of the lids to the general circulation.

In operations for strabismus cocaine is of great service, but the passage of the hook beneath the tendon and the cutting of the latter are sufficient to cause considerable pain, and, as this operation is frequently done in unruly children, a general anesthetic is often the best. In such cases I use chloroform. As a mydriatic preliminary to a thorough ophthalmoscopic examination, cocaine holds the first rank, not only because the mydriasis which it produces is of shorter duration than that from atropia or homatropia, but also because it is far less likely, in elderly people, to cause an increase of intra-ocular tension. Cocaine does not suspend the accommodation sufficiently for it to be used in the examination of refractive errors, but is often serviceable to lessen the temporary injection and unpleasant effects of other mydriatics, and doubtless aids in completing the paralysis of the ciliary muscle which they induce. The photophobia of phlyctenular ophthalmia nearly disappears after the instillation of cocaine. Painful ulcers of the cornea may be rendered easy by this local anesthetic. For the pain of iritis, or other deep-seated inflammation, cocaine is of little or no avail.

Enucleation is the most important of operations about the eye for which cocaine is not suitable; it could only prevent pain in this operation when injected into the tissues of the orbit, and as it is impossible to restrict its diffusion from the cellular tissue here, such injection has been found decidedly dangerous, and most operators now use general anesthesia.

The disadvantages attending the use of cocaine in the eye are chiefly the temporary mydriasis and paresis of accommodation it induces, a desiccating influence on the corneal epithelium, and a follicular inflammation of the conjunctiva which follows its long-continued use.

Cocaine in the ear is of comparatively limited application; when the eustachian

catheter is to be used, however, a spray of cocaine in the nose renders its passage far less disagreeable to the patient and easier to the operator. In inflammation of the ear, whether in the auditory canal only, or as is much more often the case involving the tympanum and parts adjacent, cocaine is of little or no service.

In the nose, more than in any other part of the body, we see the wonderful influence of cocaine in exciting the vaso-constrictor nerves and thus lessening the caliber of the arterioles. When the erectile tissue covering the turbinated bones is distended, perhaps even to touching the septum, the application of cocaine produces such contraction as in a few minutes to open the nose most completely. This relief from nasal obstruction, due to distension of erectile tissue, lasts a variable time, not usually more than an hour or so. The small cocaine atomizer sold in the drug stores furnishes an excellent means for its application. The patient should be warned not to snuff back the spray, as cocaine in the naso-pharynx produces a very disagreeable sensation of a foreign substance there. Lately the representative of a prominent wholesale druggist left me a sample of what was claimed to be tasteless cocaine, but two patients upon whose throats I used it, complained as much as is usual of its very bitter taste. The anesthesia produced by cocaine in the nose is sufficient for nearly all of the many nasal operations which have of late come into vogue. Before using the knife or saw for deflected or thickened septum, or the galvano-cautery, I find it best to apply the cocaine, preferably a ten-per-cent solution soaked in a little pledget of cotton, and allowed to remain in the nostril for about five minutes. In several cases I have seen constitutional effects from a four-per-cent solution of cocaine used in the nose, but they have never been at all alarming; usually there is first a slight exhilaration, followed by decided depression, but occasionally the first effect of the drug, following a few minutes after its application, is a feeling of faintness and nausea.

One peculiar effect of cocaine on the throat

should be mentioned, namely, temporary difficulty in deglutition. This has been accounted for by some on the supposition of a paresis of the muscles of the throat, while by others it is attributed to a partial suspension of the reflexes from the local anesthesia. An incautious attempt to swallow in such cases may allow the food to pass into the windpipe and excite symptoms of an alarming appearance for a few minutes.

Of cocaine in the pharynx and larynx there is also much to be said; but, as I wish to make my paper brief, I will recall only a few of its special indications.

The little operation of clipping the uvula may be done without the least pain and with only very trivial bleeding. The removal of a part of the tonsils is rendered much easier if a solution of cocaine has been painted over their surface. Localized soreness and pain on deglutition may be greatly relieved by the application of a solution of cocaine in certain cases, but only when the inflammation is superficial. I have tried cocaine lozenges, put up by local manufacturing druggists, but have had no result from them.

In tubercular laryngitis cocaine does more in my experience to lessen the pain of deglutition, and thus to prolong life, than any other agent we possess. In such cases a spray of a four-per-cent solution is very effective.

LOUISVILLE.

### WINTER MALARIAL AND HYBRID TYPHOID FEVER.\*

BY T. B. GREENLEY, M. D.

Remittent and intermittent fever, as well as a fever of a hybrid character, having been so prevalent in this locality during the past winter and spring, I have deemed the fact worthy of special notice.

Forty-five cases of remittent have come under my observation and treatment since December last, besides a number of cases of intermittent. In over forty years I do not recollect of witnessing any thing to compare with the prevalence of malarial fevers during the winter and spring seasons. In fact I do not believe I

have seen as much in any half dozen winters and springs in the aggregate.

I presume the fact can only be accounted for on the hypothesis of the unusual high temperature during this period, it having been much warmer than for many years. The range of temperature, I think, has been much higher from December to May than for the same months for forty years, which I regard as the principal factor in the production of the disease. We had but little malarial trouble of this character, comparatively speaking, during the summer and fall of 1888; in fact not so much as during the past winter and spring. The cases coming under my observation included nearly all ages, from a few months' old baby to an octogenarian. The ages of the cases ranged as follows:

1 case, 4 months old; 1 case, 9 months old; 2 cases, 1 year; 5 cases, 2 years; 6 cases, 3 years; 3 cases, 4 years; 3 cases, 5 years; 8 cases, 5 to 10 years; 6 cases, 10 to 20 years; 3 cases, 20 to 30 years; 3 cases, 30 to 40 years; 2 cases, 60 years; 1 case, 68 years; 1 case, 85 years.

These were not chronic cases hanging over from summer and fall attacks, recurring from force of habit, but entirely new cases. The character of the fever was mild, except in a few of the children. The first case I had was on December 26th.

Some of the first cases I saw puzzled me, somewhat, as to diagnosis: in fact I did not, at the first visit, in some two cases of infants, determine satisfactorily the nature of the ailment. The temperature was 104° to 105°. It has been for many years a habit with me, during the winter and spring months, if I find fever and cough as prominent symptoms in a case, to suspect lung trouble, and consequently to examine the chest thoroughly, but in my first cases of this winter's remittent fever I was somewhat nonplussed to find such examinations to give only negative results. As a rule, however, in cases of high temperature I usually exhibit quinine and Dover's powder as part of my prescription; and doing so in these cases I soon found the temperature to subside and the patients convalescent.

The duration of the disease ranged from

\* Read at a meeting of the Hardin County Medical Society, June, 1889.

forty-eight to seventy-two hours, with the exception of one case, which lasted five days.

All the cases recovered.

The treatment consisted mainly of quinine and Dover's powders, with the addition of anti-febrin and salicylate of ammonia, etc., as antipyretics in cases where the temperature ranged very high.

Since my last report of four cases of hybrid typhoid fever, read to this Society and published in the American Practitioner and News, I have treated seven other cases, which ran about the usual course of those reported, with the exception of two cases. In the first of these the patient in the second week became wildly delirious, so much so as at times to need physical control. This stage of excitement continued nearly four days. His temperature ranged from 102° to 105°. In this case I had to use more than the usual amount of sedatives. In fifteen days from commencement of attack he was convalescent.

The second case, which varied from the usual course, was a negro woman, twenty-two years old, and of usual good health. She had been sick nearly a week when I saw her. Her temperature ranged from 102° to 104° for about two weeks after I first saw her, but she had but little delirium. The most singular symptom in her case, which differed from any other coming under my observation, was the entire absence of fever, at the end of the third week, for over twenty-four hours; then a return as high as ever, for two or three days, when it went down again to normal. This phenomenon was repeated some three times before complete convalescence supervened.\*

As a rule in this fever, a relapse after entire defervescence of the fever is a dangerous condition, and renders the prognosis quite unfavorable. This patient was in bed six weeks.

The first of these two cases approximated more closely in the symptoms, during the second week, to those of regular typhoid fever than any of the whole series which have come under my treatment, fifteen of which I have heretofore reported in full. Diarrhea was present in this case.

\*Another symptom obtained in this case that I did not notice in any other, to wit, nausea and vomiting, accompanied with pain in the stomach.

This series of seven cases all recovered. Out of the first series of 11 cases, 3 died, and 1 of the second series, making a total mortality of 4 out of 22 cases, which is a loss of 18 per cent. I am no nearer now in my judgment as to the true character of the disease than when I made my first report, and still believe that the cognomen of *atypical typhoid fever*, which I first gave it, is about as appropriate as any. I treated these cases about in the same manner as those formerly reported. I would remark that all of these cases were young except one, who was sixty-five years old.

Although we have had so much fever during the past winter and spring, we have been unusually exempt from lung diseases. There was not a case of pneumonia during the whole period, and but few cases of bronchitis. I have never known such exemption from pulmonary trouble in my practice of forty-four years.

WEST POINT, KY.

#### THE NECESSITY FOR INAUGURATING A UNIFORM SYSTEM FOR COLLECT- ING VITAL STATISTICS BY THE STATES.

BY OSCAR T. SCHULTZ, M. D.

Dr. T. B. Greenley, having been appointed by his State Medical Society to report on the mortuary and vital statistics of Kentucky, performs his task and reads his report at the May meeting of the Kentucky State Medical Society. In this report, published in No. 91 of the American Practitioner and News, Dr. Greenley describes how, in order to discover where and how to get the material for his report, he first studied the laws on the collection of vital statistics of Kentucky. These laws he found good—yes, in a measure perfect—providing not alone for the collection of birth and death reports by physicians and midwives, but also for a control of such reports, by the county assessor's taking annually an enumeration of the births and deaths that have occurred in each family in his county during the preceding year; and, more than this, for the regular publication and dissemination of the matters so collected. The doctor states that he was elated at the simplicity of his task, that he knew just

where to place his hands upon a most complete series of reports for the past decade, and knew that these reports contained all the information he required to make up his paper. In his dreams he had no doubt already completed a most exhaustive abstract of said reports to place before his brethren such an array of facts and figures as would have been a monument to his patience and zeal as an investigator, and would have raised sky-high the State pride of his colleagues. But, alas! Dr. Greenley was doomed to disappointment. He was sent from A to B in quest of the State reports, from B to C, and so on through the whole length of the alphabet, before he succeeded in getting hold of a report published under the laws, and when after an exceeding worry he at last got the much coveted prize from Z, that individual serenely assured him that the vital statistics of Kentucky were not contained in the said report. Finally he traced the missing matter to the worthy Secretary of the State Board of Health, only to hear from him, in his distress, that the collected reports were being annually buried in oblivion on account of their very defective character. In utter despair Dr. Greenley is compelled to resort to Uncle Sam's Census Reports for 1880 for the vital statistics of Kentucky, so that he might not appear with bare hands at the meeting of his Society. At the close of his paper Dr. Greenley exhorts his colleagues to compel the carrying out of the laws relating to the collection of vital statistics, and indorses an amendment to the said laws drawn up by the worthy Secretary of the State Board of Health.

Now, about just such a law as the proposed amendment seeks to establish we have had in force for a number of years on this side of the lovely Ohio. Our Indiana law requires all registered physicians and accoucheurs to report all births and deaths that have come under their supervision. Also, all householders have to report all deaths and births without attendance of physicians or accoucheurs. These reports are made to the local health officer, who reports them to the Secretary of the County Board of Health, and by him they are sent to the Secretary of the State Board. A fine is imposed upon the physician, accoucheur, or

householder who fails to report a case of birth or death after he has been notified to do so by the local health officer. I believe that the reports annually collected by the Secretary of the State Board of Health are annually published in book or in pamphlet form; in fact I have in possession such a report for a certain year. And yet, if the task were imposed upon an Indiana doctor that his State Society imposed upon Dr. Greenley, viz., to prepare a report on the mortuary and vital statistics of Indiana, the unlucky wight would have to fish the material out of Uncle Sam's thesaurus for Indiana just as Dr. Greenley had to do for Kentucky. Why so? Because, if the reports collected in Kentucky are annually buried in oblivion on account of their defective character, those collected in Indiana should be regularly consigned to the same fate, and the more so since we have had no system of controlling the original reports.

Let me illustrate: I have the honor to be health officer of Mt. Vernon, and, since coming into office in January last, have faithfully tried to get as complete reports of the births and deaths occurring in our city as was possible, with what results?

From January 1 to June 1, 1889, there were collected 38 birth reports in a town of about 5,000 inhabitants. We have over 250 colored voters, and for the first five months of 1889 1 birth was reported among the colored population of Mt. Vernon, 1 for the same time in 1888, 5 in 1887, none in 1886, and none in 1885, making a total, in the first five months of the last five years among a colored population that furnishes 250 voters, at just 7 births. From January 1 to June 1, 1889, I collected reports of 42 deaths, of which but 22 were reported by physicians; 20 I took from the undertaker's books, those having died without any physician having been in attendance at the time of death. These twenty deaths would have been lost had I not possessed more zeal than my predecessors in office, or had the undertakers refused to report them to me. Now, my reports are faithfully returned to the County Health Officer, and sent by him, with the balance of the reports collected from our county, to the Secretary of the State Board of Health. The

county reports are not tabulated, arranged, and published as the reports of the Indiana State Board of Health. From the material furnished by these reports, our Dr. Greenley would be compelled to conclude that the negro loses his fruitfulness when he crosses the Ohio and settles in Indiana; that our people are rapidly dying out, the death-rate being far in excess of the birth-rate; that the Wabash and Ohio bottoms are conducive to healthfulness and a low death rate, and many more equally absurd conclusions.

Speaking only for Mt. Vernon, the fault of such defective and misleading reports does not lie with her physicians, for they report moderately well; it lies in the impossibility of the local health officer getting the reports of that very large proportion of births that take place without professional attendance, and of that large number of deaths which occur with no physician in attendance, or in case of long, lingering diseases after he has ceased attending. The fault lies, in a word, with the people who can not understand that in a civilized community every life and death is a matter of the greatest concern to the State, and who must be educated to this understanding.

It seems to me to be high time that the boards of health of the various States should meet in convention, and there determine upon some uniform system of getting complete returns of all matters pertaining to vital and sanitary statistics; and until such a meeting has taken place, and a uniform system of registration has been adopted, it is best, methinks, to use existing State rules and regulations to the best advantage possible. Of this I think there can be no doubt, that as long as different States have different sanitary police regulations, so long will we fail to educate the masses to see the necessity for such regulations, and without the intelligent co-operation of the masses all endeavors of the medical profession in this direction must needs be futile.

MT. VERNON, IND.

THE people of New Orleans are determined to do away with the system of surface drainage so long in use. They are agitating for underground drainage.

## THE NEED OF UNIFORMITY IN PHARMACOPEIAL PREPARATIONS.\*

BY A. KOENIG, M. D.

The truths that I hope to make evident to you are principally embodied in the statement that most of the preparations of vegetable origin, made in accordance with the process laid down in the United States Pharmacopeia, are of unreliable strength, or they may possibly be altogether inert. That such a condition of affairs should be tolerated in these days of advance in the knowledge of the action of medicine, and causation of disease, is almost beyond comprehension. The watchword in the medical profession in recent years is, "higher education." The course of instruction, consisting of one year under a preceptor and two terms of medical lectures, formerly deemed sufficient, is now universally recognized as being too short a period during which the necessary knowledge can be acquired, through which life may be prolonged and suffering relieved. But what must be the verdict concerning the profession that requires for admission to its ranks years of study and perfect familiarity with the human body, both in health and disease; that teaches the action of remedies on the vital functions and on pathological conditions; that describes the weapons by means of which premature death may often be prevented, and then offers these weapons in an unstable or adulterated form?

All crude drugs possessing curative properties will yield their active ingredients to the analytical chemist. The active matter can readily be separated from the vegetable tissue with which it is incorporated, and in this state of purity it can be administered with the absolute assurance that its physiological or chemical action will result. The United States Pharmacopeia makes but slight effort toward obtaining uniformity in strength in the officinal preparations. The preparations of opium and cinchona are the only ones required to conform to a certain

\* Read at the Alleghany County Medical Society, June 18, 1889.

standard of strength in active ingredients; and even these most important drugs are allowed to vary, except in one instance, to almost any degree.

The crude opium, for example, may be dispensed, provided it contains not less than nine per cent of morphine. When we consider that fifteen per cent of morphine is not an unusual percentage, it becomes evident that the effects produced by the administration of this drug must vary greatly. Further, the *opii pulvis* of the Pharmacopœia should contain not less than twelve nor more than sixteen per cent of morphine, a latitude of twenty-five per cent. The only preparation of opium, aside from the alkaloids and their salts, having a fixed percentage of its principal alkaloid, is *opium denarcotisatum*, which contains fourteen per cent of morphine.

With regard to cinchona preparations, the requirements are even more lax. Under the name of cinchona, the Pharmacopœia admits the bark of any species of cinchona containing at least three per cent of its peculiar alkaloids. This, it will be admitted, is a step in the right direction, but the *infusum cinchonæ*, which the Pharmacopœia directs shall be made from this bark, will present of necessity wide range of strength. Under the term *cinchona flava*, the bark of the species *calisaya*, containing at least two per cent of quinine, is recognized. From this variety an extract, a fluid extract, and a tincture may be made, and they also present wide ranges of strength. The bark of the species *succirubra* is known as *cinchona rubra*, and must conform to the standard of strength required for the yellow bark. The compound tincture made from this bark is also of the same unknown strength.

These are the more reliable preparations of vegetable origin for which the Pharmacopœia furnishes a formula. The remaining large number, many of which are of great value as remedial agents, can never be relied upon. Their variability may depend on several causes. The climate and soil in which a plant grows materially modify the proportion of active ingredients. The age

of the plant must also be taken into consideration. And finally the almost incredible fact that men will jeopardize the lives of their fellow-beings, in their inordinate greed for wealth, by adulterating the more expensive remedies, forces itself on whomsoever investigates the drugs offered in the market. Crimes of this nature should be met with severe punishment, but as long as the active ingredients of pharmacopœial preparations are an unknown quantity, it becomes a matter of difficulty to prove the sophistication and mete out the deserved punishment.

The strength of such important preparations as tincture of aconite, tincture of digitalis, tincture of *veratrum viride*, tincture of opium, and tincture of belladonna can, under our present methods, be determined only from their effects produced after administration; and by the time this has been accomplished the indication for their employment may have passed, or the patient may have succumbed to the disease. This is true not alone of the tinctures enumerated; extracts, fluid extracts, etc., are no more reliable.

The only remedy for this unfortunate condition of things that seems at all feasible would be to exhaust the active drugs of all of their active constituents, assay the product, and require the preparation to conform in strength to a percentage to be determined upon by the Committee on Revision of the Pharmacopœia. That has been done in the case of at least one drug, namely, *elaterium*: this, one of the most valuable hydragogue cathartics, fell into unmerited disrepute by reason of its unreliability of action. At the last decennial revision of the Pharmacopœia it was deemed advisable to drop *elaterium* from the list of official drugs and substitute in its place its active principle, *elaterin*, which can be separated from the inert vegetable matter composing the greater part of *elaterium* by chloroform and afterward crystallized. In this form it becomes an absolutely reliable drug and may be administered with scientific precision. To facilitate its administration, some substance having no appreciable effect on the vital functions must be

added; this is found in sugar of milk. The trituratio elaterini is composed of 10 parts elaterin and 90 parts of milk sugar, producing thus a preparation of definite strength.

In view of this fact, the query, Why can not other drugs be treated similarly? presents itself. Why can not ergot, aconite, digitalis, and others be transformed into solid or liquid preparations of definite strength, thereby assisting to place medicine on a thoroughly scientific basis, and at the same time to prevent the skepticism that frequently characterizes the aged physician, whose life has been spent in an oftentimes ineffectual warfare against disease with these defective medicines? This delusion regarding the value of medicines as curative agents can unquestionably be traced to an oversanguine confidence of youth, engendered by the positive statement of teachers and authors, followed by the disastrous results obtained too often by the administration of inferior or adulterated substances recommended for the cure of disease.

Drugs furnished by the mineral kingdom may be obtained pure with much greater ease; nevertheless some of these are notoriously impure, while many other substances, such as volatile oils, etc., owing to the leniency of the law, are so adulterated as to be practically devoid of medicinal activity. What, it might be asked, is the remedy for this condition of things? Primarily it will become incumbent on the profession to establish a standard of strength for all the preparations made from drugs having known active ingredients. This being done, all deviations from the standard should render the manufacturer amenable to the law; and, finally, all persons convicted of adulterating officinal preparations made from drugs derived from the vegetable or animal kingdoms, as well as of chemicals used as remedial agents, should be dealt with with a severity little short of that accorded murderers. To bring about this needed reform, the proper course would undoubtedly be to place the manufacture of all medicines under the same restrictions that hedge the practice of medicine and pharmacy. Physicians must furnish evidence to the authorities of fitness to practice their high calling; pharmacists must

conform to the same law; but any manufacturer so disposed may flood the market with inferior pharmacopeial preparations with perfect impunity. It is a matter of every-day experience that the price of valuable remedies varies in open market as much as one hundred per cent.

The question that confronts you, gentlemen, is, Are your prescriptions compounded with these cheap preparations? The mere fact that they are in the market indicates that there is a demand for them. There is but one solution to this deplorable condition of the drug trade, namely, to place it under governmental supervision. Every bottle of medicine in the retail drug store, used in compounding prescriptions, should bear the government's stamp of genuineness. Without stringent precautions of this nature, the physician will continue to do battle 'gainst the scythe of Death with a leaden sword.

PITTSBURGH, PA.

### THE DIAGNOSIS OF URETHRAL STRICTURE OF LARGE CALIBER.\*

BY R. W. STEWART, M. D., M. R. C. S.  
Physician to Mercy Hospital, Pittsburgh.

A prominent authority on genito-urinary diseases says: "The least contraction at any point in the urethral canal has been demonstrated as capable of causing the indefinite continuance of a urethral discharge, and even of establishing it *de novo* without venereal contact." The same authority also says: "Chronic urethral discharge, commonly called gleet, is the signal which nature hangs out to notify the intelligent surgeon that an obstruction to the normal working of the muscular apparatus of the urethra has occurred; that plastic material laid down in the antecedent inflammatory condition has begun to contract the normal urethral caliber, whether it be twenty or forty millimeters in circumference, and that nothing short of a complete restoration of the normal caliber of the canal will afford a permanent cure." (Otis, "Stricture of the Male Urethra," pages 20 and 75.) Those who are accustomed to the treatment of

\* Read at Alleghany County Medical Society, June 18, 1889.

urethral diseases are aware that the treatment of gleet constitutes perhaps the most important as well as the most troublesome part of urethral surgery; and if, as there are good reasons for believing, the successful treatment of gleet consists in the majority of cases of the removal from the urethra of some contraction in its caliber which keeps the adjacent mucous membrane in a condition of chronic inflammation, it will be evident how important it is that some means should be placed at our disposal by which urethral stricture may be readily detected and accurately located.

For this purpose various instruments have been devised; those in general use are the blunt-pointed steel sound, the bulbous bougie and the urethrometer.

The blunt-pointed steel sound, as recommended by Sir Henry Thompson, is doubtless useful for the detection of stricture of small caliber through which only small instruments will pass. But these strictures are not those with which we have most to contend; it is the stricture of large caliber, through which a medium-sized steel sound will pass without perhaps a noticeable obstruction. The blunt-pointed steel sound is certainly inadequate as a means of detecting strictures of large caliber, and in the presence of superior instruments should be relegated to obscurity.

The bulbous bougies are in many respects superior to the steel sound, but to their use may be urged several serious objections which they have in common with the steel sounds. It is necessary to have a complete set of bougies, as each bougie only gauges a particular size. Where there is more than one contraction of the urethra, should the posterior contraction be less than the anterior, the bulbous bougie will not indicate its presence until the anterior contraction is dilated sufficiently to pass an instrument the size of the posterior stricture, and a contraction of the meatus, so commonly found, renders it useless until the meatus is cut. Another objection to these instruments is the necessity of trying bougie after bougie until the proper size is obtained.

To obviate these objections the urethrometer was devised. There are several varieties of this instrument, all agreeing, however, in their general construction and method of using. This instrument has a bulbous extremity, which can be expanded to any desired extent by means of a screw at the handle. An index at the handle indicates in millimeters the size of the expanded bulb. The urethrometer is free from the objections of the previous instruments, in the fact that it can be adjusted so as to measure any stricture of large caliber, and that a contracted meatus or a narrow anterior stricture forms no obstacle to the detection of deeper strictures. It must be admitted that the urethrometer is an improvement on the sound and the bougie, but it is perhaps better in theory than in practice, for in practice it has serious objections. Following the instructions of Prof. Otis, we introduce the urethrometer down to the bulbomembranous junction, and by means of the screw at the handle expand the bulbous extremity "up to a point which is recognized by the patient as filling it (the urethra) completely, and yet easily moving back and forth. The index at the handle then shows the normal circumference of the urethra under examination." This is all beautiful in theory, but very different in practice; if we rely on the patient's feeling his urethra filled by the bulb we rely on a very unstable guide, because one patient may consider his urethra filled as soon as it is touched by the expanding bulb, while another will not consider his urethra filled until the pain of distension forces an admission from him; and a patient may at different parts of his urethra, according to its tenderness, form different estimates as to when it is distended. The only reliable indication of the distension of the urethra is by moving the urethrometer along the urethra and feeling whether it is held or not, and this may necessitate considerable moving back and forth of the instrument, exposing the urethra to considerable irritation. A contraction is recognized by feeling an obstruction to the withdrawal of the urethrometer when the

bulbous portion is reduced just far enough to slip through the contraction; at the same time a note is taken of the size and depth of the stricture. Having passed through the stricture, the bulb is again enlarged until the urethra is filled, and so on.

All this requires considerable skill and a delicacy of manipulation which is seldom attained by any but the expert accustomed to the handling of urethral instruments. In the hands of the expert the urethrometer may give satisfaction, but in other hands it will perhaps be oftener a source of embarrassment than a source of information.

To my mind the requirements of an ideal instrument for the detection of large strictures would be an instrument the use of which did not require special skill, and which would make an accurate record of the urethra at all parts. In considering how an instrument could be made to fulfill these requirements, it became evident that the *tactus eruditus* of the surgeon must be replaced by a mechanical contrivance, and that, instead of an index on the instrument, a diagram representing the size of the urethra at all parts must be substituted. Acting on these principles, I have had an instrument constructed which I have called a urethragraph. It consists of a canula, terminating in two movable blades, which present a smooth convex surface to the urethra. This instrument is introduced with the blades closed as far as the bulbous-membranous junction; then with the left hand the carriage containing a strip of cardboard is introduced into the slot in the urethragraph. With the index finger of the right hand a movable pin is touched, which liberates a spring contained within the handle of the instrument. This spring, on being liberated, expands the movable blades until a certain adjustable pressure is exerted against the urethral walls. The carriage is now held stationary with the left hand, and with the right the instrument is withdrawn from the urethra. The spring within the handle is so adjusted that the movable blades press against the urethra with an equal pressure at all portions, whether it is strictured or

not. As the movable blades move along the urethral wall, they follow its contour, no matter how irregular its shape, and at the same time an arrangement under the handle draws a diagram on the cardboard corresponding exactly with the width of the urethra at all parts. This cardboard is spaced longitudinally into millimeters, and transversely into inches, so that at a glance the size and position of any portion of the urethra can be seen. The advantages claimed for this instrument are:

1. The rapidity with which an examination of the urethra can be made.
2. The simplicity of the examination, so that it offers no greater difficulties than the introduction of a sound.
3. The accuracy of the results.
4. A uniform pressure is exerted against the urethral wall at all parts, so that the patient does not suffer from the instrument being obstructed in passing through a stricture.
5. This pressure can be adjusted at the will of the operator.
6. A record is obtained, so that at a glance the condition of the urethra at any part may be ascertained.
7. These records may be filed away and kept for future reference.

PITTSBURGH, PA.

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## Societies.

### ALLEGHANY COUNTY MEDICAL SOCIETY.

Special Meeting, June 18, 1889, William F. Knox, M. D., President, in the chair.

*Foreign Body in Bronchus.* Dr. Rigg presented a small piece of bone and its history: On the 28th day of May, 1888, Mr. O'Neil, while drinking a bowl of soup, choked on something; after vomiting, he put his finger down his throat and succeeded in dislodging it. Not feeling relief completely after this occurrence, he consulted a physician, who examined his throat and found nothing there, and merely prescribed for the irritation of the throat. Two days later he developed a severe cough; he consulted a physician, who examined his larynx, his vocal organs, and throat as far as possible,

and stated that he could not see any thing wrong—he had bronchitis, which I think was correct. About the first of August he came to me with this history, stating that he had been perfectly well up to the date of the accident. He had no fever; his pulse was very little excited; he had a very severe cough, mucous rales over both lungs, more particularly over the left lung. I examined the throat, larynx, and vocal cords, and they seemed to me to be in a fairly healthy state. He got much better and went to work. In December he ran down and developed a severe pneumonia of the right side. From the first of February he improved slowly but steadily until the latter part of March, when he improved more rapidly. He got out of doors in April, walked around and gathered up very satisfactorily. Still, however, the cough remained; the right side improved, the left side remaining pretty much the same throughout. On the 1st of June he began to run down again, looking more like he had looked when he came into my hands in August. On the 4th of June he expectorated some pure blood while coughing—about a teaspoonful of pure, bright blood. He coughed up mucus afterward. He came to me and said he felt something jagging in his throat. I paid very little attention to that, however, but saw that he was running down. This was on the 4th of June. On the 11th, after coughing, this bone came up. Since that time the patient has been improving, he has felt more comfortable, and seems to be improving to some extent; however, the damage done to the lungs is extensive and the ultimate outcome is uncertain.

Dr. Munn: Such cases usually go to the family physician, and in many cases any foreign body in the trachea or in the bronchi is overlooked because the physician has not an opportunity for frequent examinations of such cases. The case in its beginning reminds me of another which came under my own observation. An old lady of eighty-two years came under my notice complaining of a bone in the throat. A superficial examination of her throat revealed absolutely nothing; no reddening, no swelling. The second examination also resulted in revealing nothing, but upon a third exami-

nation I discovered between the larynx and the base of the tongue a pin, whose point was imbedded. It was almost inaccessible by curved forceps. After three attempts to seize it with curved forceps, I managed to gain possession of it by using long, straight forceps, passing them back on the body of the tongue. The woman was relieved of all uneasiness and had no trouble with it afterward. I think the body was one which might have easily been overlooked, and led to a serious formation.

Dr. Koenig read a paper on the Importance of Uniformity in Pharmacopeial Preparations. (See page 70.)

Dr. Macfarlane reported a case of fatal alcoholic poisoning in a child. A boy, aged five years, was in good health, playing on the street, when his mother called him in for dinner. A few minutes elapsed from the time the child was called until the mother was prepared to place him at the table, not over twenty minutes. When she looked around for the child she saw that he appeared to be intoxicated. In the sitting-room there was a bottle containing some six or eight ounces of whisky, along with some cake—a visitor had come in and been treated by the mother. She found the bottle empty. This occurred between twelve and twenty minutes after twelve. The child was put to bed to sleep the liquor off. After the child had taken the whisky it became blanched, and this was followed, in an hour or so, by purging and vomiting. About six o'clock I saw the child. It had a rapidly running pulse and a normal temperature. The pupils of the eyes were dilated and did not respond to light. There was slight twitching about the face, and an occasional tremor about the hands and fingers. I put my nose in the child's breath, and it was identical with that of a man who has been intoxicated by whisky. I did what I could for the patient under the circumstances. I gave it bromide of potash and coffee. I saw it again at 11 o'clock, and found it in general convulsions. It died about 11:30, eleven hours from the time it took the liquor.

Dr. Jones reported several cases of scarlat attacks of several incident diseases. I have recently had under my care a child with his second attack of scarlet fever. I had

treated this child a couple of years ago for the same disease; and recently another child died with diphtheria, whom I had treated the second time for scarlet fever. I also treated this child the first time. I had two cases of measles in two children in one family, both of whom had two attacks of that disease within six weeks. They got over the first attack and were up and about, and almost well, seemingly, when they were again taken down with the disease.

Dr. Munn reported a case of pelvic peritonitis caused by violent pressure on the uterus *post-partum*. The case I relate this evening illustrates the probable and possibly frequent result of the injudicious use of Credé's method of completing the third stage of labor, and the injury the meddlesome midwifery is apt to inflict. I recently visited a woman in labor for the purpose of removing a retained placenta. The women in attendance had made traction with the cord, and partially detached the placenta. The woman was bleeding freely. Alarmed at her condition, I immediately placed my hands above the fundus of the uterus, and exercised what I thought was a proper amount of compression—what I supposed was the exact method of Credé. The hemorrhage was controlled promptly. I continued the pressure, and a moment later the hard ball, which could be felt in my hands, disappeared. Examining through the vagina, I felt a rounded tumor in the posterior *cul-de-sac*. I had exercised too great violence, and retroflexed the uterus. The patient progressed favorably. A week later she was seized with all the symptoms of peritonitis. For two or three weeks her condition was so serious that I daily expected her death. After that she made a slow recovery. For several months she came to my office for treatment on account of pelvic pain. I could discover nothing but an erosion of the cervix, and this I treated by the application of iodine and solutions of nitrate of silver. The thickening which resulted from the peritonitis was so marked that I could necessarily make no positive diagnosis. Under general tonic treatment she regained a fair degree of health, but was never able to attend to her household duties, and still suffered from

pelvic pain. She passed out of my hands. In the spring of this year she again returned to me. The thickening in the pelvis had disappeared so that I was able to determine the exact condition. There was a dislocated ovary and tube. This was very tender. On the 13th of April, that is, more than eleven months after the labor, I opened the abdomen, with the assistance of Dr. Riggs and in the presence of Dr. Foster and Dr. Hazzard. There were all the evidences of severe pelvic peritonitis. The right ovary and tube were prolapsed; the ovary itself was cystic; the pelvic peritoneum was covered with granulations. I removed the ovary and tube, and she recovered. She is now able to do almost all kinds of household work, and is entirely free from pain. I attribute the displacement of the ovary and tube, as well as the retroflexion and the pelvic peritonitis, to undue violence exercised by myself. I think the case is interesting and instructive, and at least calls for greater care in the use of this method of causing the expulsion of the placenta.

Dr. Buchanan: I do not think it is clear that the Credé method is to blame for the result in this case. I think it would be very difficult to positively decide that it was violence done by the hand, and not infection, which was causative of the inflammation. According to the statement, there had been efforts at the removal of this placenta by attendant women before Dr. Munn arrived. He also made an examination, and although symptoms of trouble did not come until a week after the manipulations, I see no reason why this should militate against the probability of sepsis, especially as we have no account of the after-treatment, douches, etc. The related trouble can not justly be ascribed to Credé's method. It is probable that this was a case of pelvic cellulitis or pelvic peritonitis from infection.

Dr. Blume: Credé's method never produces septicemia. Whenever the uterus is emptied by Credé's method there may be left behind some shreds of membranes or parts of the placenta; these may become decomposed, and so cellulitis or local peritonitis may be the final result. This can not be due to Credé's method. All cases of cellulitis, metritis and

peritonitis, during the puerperium, are the result of infection. If the vagina is clean, the finger aseptic, or the instrument aseptic, there is all probability that by introducing the hands or instrument into the uterine cavity to remove parts of the placenta sepsis will not follow. I wish to make one remark in regard to retroflexion of the womb. It is hard to understand how a womb as large, reaching to the umbilicus, can be retroflected by Credé's method. It might be possible about three or four days later. I believe it is not possible just after labor. There are many cases of Credé's method and its results reported, but as far as I know, none of retroflexion. The uterus is lying on the spine, and can not be turned over.

Dr. T. D. Davis: I was struck by the same thought brought out by Dr. Buchanan. I do not think Credé's method is to blame for this trouble as much as is the doctor who fails to properly employ it. One of the advantages is that you retain complete control of the uterus by your hand. If you simply bear upon the fundus, you do not carry out Credé's method. Credé's method consists in grasping the fundus of the uterus with the fingers well placed around it, and holding it well within the grasp of the hand. The fingers and thumb grasp the uterus, and then by gentle pressure cause contractions of the uterus. No later than this morning I saw the placenta thrown into the bed by the powerful contraction of the uterus excited by that method. The conditions that followed in this case, whether they were septic and whether the pressure made by the doctor caused retroversion, the doctor is most qualified to determine.

Dr. Munn: In stating the case, I said it was not an argument against the employment of Credé's method, but against the improper employment of it and the use of undue force by inexperienced persons. The point to which I wish to call attention is the possibility of doing damage when you attempt to employ Credé's method. As to whether this case was due to sepsis, it does not come under the classical description of sepsis. Fever should begin within five or six days. It was fully a week before this trouble began. I should attribute

it to Credé's method because I believe that the circulation of the uterus was more or less interfered with and the peritoneum was damaged, while the peritonitis was not developed until the seventh or eighth day. As to whether retroflexion of the uterus is possible or not, in this case it no doubt happened.

Dr. McMullen: I remember during last winter placing my ice-cold hands over the uterus in a case of labor with hemorrhage. This was followed by a violent contraction, and the placenta was thrown clear out of the vagina. I tried this again a few times, and it produced the same effect. Cold is not sufficiently appreciated for this purpose. It is very effective. Dr. Munn is too severely just in blaming himself for the bad result of this case.

Dr. Bigg: The Credé method, I believe, is sometimes abused, particularly in the hands of inexperienced persons. Ten years ago I used the Credé method of expelling the placenta, not with the same discretion, however, that I should have employed it. Inversion followed. I replaced the uterus, and remained with the woman nearly all day to see whether any thing would follow. There were hemorrhages until I got the uterus replaced. It is necessary to make light pressure when the uterus is up, when there is a contraction; and when there is no contraction relax the pressure. Simply stimulate the uterus when we have a contraction. I think with that precaution we will seldom have any trouble from that method; I think it decidedly the best one we have.

Dr. Stewart exhibited an instrument for measuring the caliber of the urethra, and read a paper on the *Diagnosis of Urethral Stricture of Large Caliber*. (See page 72).

Dr. McCann: I think this has certain advantages over other urethrometers which I have examined. It seems of more value than any like instruments. All the others are exceedingly cumbersome, difficult to manipulate, and practically useless. The advantage to this are really the simplicity and the fact that it lays before you a picture of the condition of the urethra. I am at a loss to understand how or why the urethrometer should be required for the treatment of stricture which is twenty

to forty millimeters in diameter. I find persons who have strictures in which No. 16 English can be passed. I have been in the habit of telling such persons that they have no stricture, and I am satisfied this statement is true. The human urethra is not a tube like a gas-pipe, it is not something which is invariable in its size and caliber; it varies with different individuals much as the size of the male organ varies. I heard a prominent professor, one of the leading professors in an eastern school, state that he had cut a man up to No. 40, and the man came back again and stated he had another stricture, and he had felt it with his finger. Now, such treatment is malpractice, and malpractice of the grossest kind. The result is that men go through life dribbling their urine, being unable to propel a stream. These people are a profitable source of revenue to men who are unscrupulous. With such people I think the instrument invented by Dr. Stewart would probably be valuable; it would show them something tangible which they could gaze upon, and would satisfy them they had no stricture. But the stricture which will permit this instrument to pass will readily permit the passage of sounds of such size that the persistent use of them for a short time will cure the stricture.

## Reviews and Bibliography.

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### Abstracts and Selections.

**CHLOROFORM IN OBSTETRICS.**—Chloroform being the anesthetic best adapted for obstetrics, and the one usually preferred in the vast majority of cases, the question we must ask is, What amount of danger is there from its use? The most searching inquiry upon this point is necessary, since time has strengthened in surgical experience the strongest objection ever made to obstetric anesthesia. The highest authorities have recognized the irregularity of chloroform in full doses. A statement of the fact might seem to carry with it an abandonment of the agent. It would probably do so were it not that there is a counterpoise, an ex-

perience which can be justly termed immense. The records of that experience have been carefully searched, and every case as closely scrutinized as possible. There has been a good number of cases in which death was imputed to chloroform, but with manifest injustice. Justice and science alike demand that the remedy shall not bear the odium of causing death, unless it has been properly used under circumstances in which it alone could have been the cause of death. It is impossible to give in this article the details of the cases. In some the agent was administered by incompetent persons; in others by the patient herself. Many of them rest on hearsay evidence; the time and place of the occurrence and names of persons are entirely lacking. In some cases a severe complication of labor was present, such as convulsions or placenta previa, which frequently alone is a cause of death. Until quite recently it could be truthfully said that not a single death had ever taken place under chloroform in labor when it was administered by a competent person. There are many circumstances attending parturition which tend to ward off or prevent danger from the administration of chloroform. Sex is one of these; the records of deaths from this agent show nearly two men to one woman. The recumbent position of labor is an element of safety. Emotion is eliminated as a factor. Many deaths under anesthetics have been, without doubt, purely emotional. The suffering woman accepts relief more than willingly; she has no dread of its means. A far stronger element of safety lies in the slow and gradual administration during labor. The danger of a strong impression of chloroform, and of the rapid inhalation of air highly charged with its vapor, was early pointed out; the warning has often been repeated since; yet many deaths from this cause have occurred, and patients have been exposed to danger in this way, as has been seen even in obstetrics. But so few have been the accidents in obstetrical practice compared with the vast number of patients submitted to anesthesia, both in natural and operative labor, that these points alone have not seemed satisfactory, and attempts have been made to find in some condition of the parturient woman a special source of safety. Campbell makes a strong plea for the efforts attending labor as the safeguard. The condition of anesthesia is one of cerebral anemia; expulsive efforts tend to counteract this. But anesthesia is something more than anemia of the brain, and effort is exerted during but a small portion of labor. A better argument may be made for the existence of pain as the element of safety. The record of chloroform mortality shows a very

large proportion of deaths among those about to undergo an operation and during operations of a trifling character. A careful study of the subject of accidents from chloroform during parturition justifies the following statements:

1. But one well-authenticated case of death is on record where the administration was by a medical man, and in that case no necropsy was made.

2. Dangerous symptoms have occurred but a very few times, and then almost always from the violation of the rules of proper administration.

3. The danger when chloroform is used only to the extent of mitigation or abolition of the suffering of childbirth is perfectly *nil*; when carried to the surgical degree for obstetric operations the danger is far below what it is in surgery.

4. No proof can be furnished that the parturient woman enjoys a special immunity from the dangers of anesthetics, although facts seem to indicate that such exists. Her best safeguard lies in the care and watchfulness of the administrator.

The effects of chloroform upon the contractions of the uterus require brief notice. It has been maintained by much diverse testimony that by chloroform the uterine contractions are not affected, that they are augmented, that they are diminished, and that they are suppressed. Authorities of equal standing could be quoted in support of each of these propositions. The first attempt must be to explain such wide differences of opinion based upon observation of facts, and then to give judgment according to the weight of evidence and the character of the observers. This explanation of such varied and opposite testimony is not difficult in view of the varying circumstances under which, and the individual peculiarities of those to whom, anesthetics are administered. (1) A temporary cessation of the pains upon commencing inhalation was early observed, and by Simpson, Channing, Siebold, and others was recognized as temporary. It is doubtless largely due to emotional elements, which a little encouragement and time suffice to cause its disappearance; but there can be no doubt that this has by some observers been considered permanent and caused an adverse judgment of the process. (2) Anesthesia is much more frequently followed by diminution or cessation of the pains in the early stage of labor than later, when reflex actions are powerfully excited by the descending head. (3) The effect upon the pains will vary according to the depth to which the anesthetic action is carried. This depends upon the ascending and progressive

action of the agents upon the nervous system. If analgesia alone is caused, the uterine contractions are not interfered with; carried deeper, they are diminished in force; and in narcosis they may be entirely suspended. No one who has attempted a difficult version without and with anesthetics could doubt their power over the uterine contractions. (4) There can be no doubt of the existence of individual peculiarities in this respect. In certain cases small doses will so affect the pains as to compel the abandonment of chloroform. (5) Prolongation of administration, if carried at all beyond the stage of analgesia, has a tendency to weaken the force of the pains and lengthen the intervals between them. Under these varying circumstances it is not surprising that there has not been harmony of opinion among observers. It is a singular fact that very strong testimony as to non-interference of chloroform with the efficiency of the pains has been rendered by strenuous opponents of its administration in normal labor and by men who have observed it carried to the surgical degree for operations, such as severe forceps deliveries and repeated cephalotripsies. Both Depaul and Pajot are positive that chloroform does not exercise any influence upon uterine contractions. A careful review of all the testimony together with an estimate of its value, based upon the amount of experience and character of those who render it, leads to the following conclusions:

1. The action of chloroform upon the uterine contractions may vary according to the period of labor and the peculiarities of the patient, and especially with the degree to which anesthesia is carried.

2. A temporary diminution or cessation of uterine action is not at all infrequent. Occasionally, however, chloroform permanently abolishes the pains.

3. Obstetric anesthesia or analgesia has no effect, as a rule, upon the uterine contractions.

4. In surgical anesthesia the energy, frequency, and duration of the contractions may be, and generally are, lessened; in deep narcosis uterine action is in abeyance.

5. Upon withdrawal of the anesthetic, and with the disappearance of the anesthetic effect, the uterus promptly resumes its functions.

6. The tendency of the agent is then toward causing a diminution of uterine action, and this tendency should be kept constantly in mind by the accoucheur.

*Influence in Promoting Hemorrhage after Delivery.* An inquiry as to the influence of chloroform upon the contraction and retraction of the uterus immediately after delivery is closely allied to one as to its effect during labor. That

authorities should differ widely upon this point is not surprising when the difficulties which attend a clinical study of it are considered. Hemorrhage is not an infrequent sequel of labor, and it is evident that the *post hoc* and the *propter hoc* are easily confounded. Blot says, "It has seemed to me that the quantity of blood lost immediately after delivery has been somewhat (*un peu plus*) more abundant than usual." Cazeaux gives but a doubting affirmative answer to the question whether chloroform favors hemorrhage. Both Hall Davis and Edis state their belief that anesthesia has a tendency to favor *post-partum* hemorrhage. If these expressions are ambiguous, they clearly show that the question is not an easy one even to one of large experience. However diverse opinions may be upon this question, the practitioner may do well to bear in mind in practice the tendency of the agent he is using.—*Dr. F. W. Allright, London Lancet.*

**ON THE OPENING OF BUBOES**—The best method of opening a bubo is a matter of much greater importance than at first sight appears, and especially to the military surgeon, who has so many of them to treat. I believe that a very considerable reduction of his "constantly sick" would be the result of a procedure different from that which now prevails.

Surgeon-Major Adye-Curran, in a recent number of the Journal, has drawn attention to the advantages of aspiration *versus* free incision in the evacuation of suppurating buboes, and the method is, I am quite sure, a good one.

It is now some four-and-twenty years since I abandoned the free incision by which I was taught to open a bubo, a method of opening which is still very generally adopted, apparently orthodox, and perhaps, in civil life, necessary. For so many years have I invariably opened a bubo by a mere puncture with a narrow bladed bistoury, and so very well satisfied have I been with the good results, that I shall continue the practice. By adopting this method that most odious spectacle, "an open bubo," is avoided, as well as the reproach of a protracted cure, not in all cases by any means, for sinuses will form that must be opened up, and the consequence of neglect or a vitiated state of constitution must be dealt with.

It is necessary to observe that to obtain the best results a bubo should be opened at the proper time; not too soon before a sufficiency of morbid deposit has broken down, nor too late when the vitality of the tissues may have become impaired. The experi-

enced operator chooses the right time, which is probably a few days after the presence of pus has been diagnosed. The small opening made by the bistoury will often be found closed the following day; it may be reopened by a blunt pointed probe if necessary.

The puncture is much less painful than the free incision, and it of course has the advantage of leaving but a very small mark, while it has no disadvantage, as it can at any time be converted into as long an incision as may be thought necessary. I am quite certain that the opening of a bubo by a free incision, instead of by puncture often extends the duration of a case from days to weeks, or from weeks to months. I hope, therefore, that those who condemn the free incision may have many followers, and that "open buboes" may be relegated to the opprobria of the past; at all events, so far as the deliberative action of the surgeon is concerned in their production.—*J. H. Boileau, British Medical Journal.*

**INTESTINAL OBSTRUCTION.**—At a meeting of the Edinburgh Medico-Chirurgical Society a discussion on the diagnosis and treatment of intestinal obstruction was opened by Mr. A. G. Miller, who for practical purposes, more especially from the point of view of diagnosis, made a triple subdivision: (a) acute obstruction, (b) subacute, (c) chronic. Exact diagnosis was always difficult, but especially so in the cases belonging to the second group. Five cases were described, all of which proved fatal. This result was doubtless due in part to the delay preceding the operation. When they should operate would always constitute the practical difficulty.

Mr. Duncan inclined to divide the cases into acute and chronic. The chief point was the diagnosis. They had to bear in mind, in the first place, that there was a considerable danger of confounding other conditions with obstruction. There were various conditions of the bowel wall or external to the wall, there were internal conditions and there were certain reflex conditions, all of which might give rise to symptoms simulating those of true obstruction. In illustration of the last group, he described a case which had been presented to him, in which alarming symptoms, occasionally like those of obstruction, were found to be reflex in origin and dependent on an inflamed testicle, only partially diseased. In connection with obstruction due to a mass of feces, Mr. Duncan spoke of the consensual value of the lung tube, which might be

passed further up the intestine than was usually supposed. With it he had succeeded in breaking down such a mass situated high up, which had resisted other treatment and given rise to serious apprehensions.

Dr. Affleck began by emphasizing the fact that some cases of apparent obstruction were amazingly tractable. He had more than once reduced intussusception in children by means of inflation with bellows. In a case with most urgent symptoms, due to fecal accumulation, he had succeeded perfectly with the constant current. His experience of operation was unfavorable. One of the most important causes of this was delay. In every case they should exclude hernia, and the rectum should be examined. If the patient were a child, intussusception was suggested. The patient's habit of bowel must be carefully inquired about. The history of old inflammatory attacks might be important. Constipation was of less value by itself than when associated with the absence of the passage of flatus. The character and situation of the pain might prove to be of importance. Vomiting had been said to be greater the higher up the seat of obstruction. This might be so, but he was inclined to think that in some cases the vomiting was entirely reflex, and depended little on the actual seat of obstruction. Then the amount of meteorism was important, being, of course, more pronounced the lower the obstruction. He doubted whether Mr. Treves' suggestion of auscultation of the colon was practically of much service. In respect of treatment, purgatives might first be tried. It was only the failure of ordinary and safe purgatives which excited the suspicion that they had to do with a case of obstruction. Enemata, galvanism, massage, and opium, all had their own place. In judging of operation, each case was to be taken *per se*.

Mr. Cathcart argued that more might be made of the analysis of individual symptoms. Thus, in studying pain, they must observe accurately its seat, its character, whether constant or intermittent, and whether accompanied by tenderness on pressure. As a rule, this latter condition would be found to be associated with peritonitis. So in respect of vomiting, it was usually supposed to be ominous when a simple belching of fluid occurred without actual retching.

Dr. William Russell spoke of the difficulties of exact diagnosis, illustrating his remarks from the records of *post-mortem* work. In his experience, the prognosis in connection with operations was bad.

**KRAUROSIS VULVÆ.**—In 1885, the late Professor Breisky described a peculiar degeneration of the tissues of the vulva, to which the name of kraurosis vulvæ was given. The labia minora especially undergo atrophy, and owing to the degeneration of the vestibular structures, the meatus urinarius gapes, and becomes liable to severe irritation, or even ulceration. The skin of the perineum and the clitoris share in the atrophic process. The sudoriparous and sebaceous glands of the labia become diminished in size and in number. Dr. Janovsky, of Prague, has recently published observations on kraurosis vulvæ in the *Monatshefte für praktische Dermatologie*. He studied six new cases, and found that their etiology was obscure. Therapeutic aid was of no avail. In one instance he believed that he could trace the disease to edema, which was followed by a sclerotic process, and consequent atrophy of the involved tissues. Dr. Janovsky also considered that chronic gonorrheal discharges and venereal ulcers at least predisposed to kraurosis, if they did not actually cause that obscure and somewhat interesting affection.—*British Medical Journal*.

**THE AMOUNT OF ALBUMEN IN DIET.**—Medical men are in favor of the use of animal food in moderate quantity. But it is very difficult, physiologically speaking, to say what is a moderate quantity, and most men eat as much flesh meat as they feel inclined for without any consideration of the kind. Another attempt to estimate accurately the albumen actually required for tissue change has been made recently in the chemical laboratory of the Berlin Pathological Institute by Dr. Kumagawa, a native of Japan. Five series of experiments were made upon himself with the following diets, namely, one series with the usual Berlin diet, two with a mixed Japanese diet, and two with a purely vegetable diet—boiled rice. The results of feeding on the last diet are given in the *Centralb. f. d. med. Wiss.*, No. 12, 1889. The experimenter's age was twenty-seven, his weight 48 kilograms; and the problem was to ascertain the minimum albumen supply requisite to keep up that weight, other proximate food being afforded in due quantity. Previous experiments showed that for this a diet sufficed which corresponded to 2,300 calories, and which contained from 70 to 90 grams of albumen per day. The rice diet afforded 2,500 calories, but contained very little albumen, of which the daily supply was 50.5 grams of carbo-hydrates 569.83; the caloric value of

the albumen was 6.3 per cent, of the carbohydrates 93.7 per cent. On this diet, there was actually a gain of albumen in the body of 5.884 grams in nine days—that is, 173 grams of flesh—and the body-weight increased 0.4 kilos. Thus it is shown that an adult may, upon a diet having less albumen than is destroyed in the fasting condition, not only preserve intact the nitrogenous equivalent (as also Hirschfeld's experiments have proved); but may even increase the albumen deposited as flesh, if only the diet afford sufficient caloric.—*Ibid.*

WHAT WAS THE CIRON?—In many medical works of the sixteenth, seventeenth, and eighteenth centuries, the ciron, syrone, or sirone is mentioned as a hand-worm. The word "ciron" is French, and is given in several French dictionaries as meaning a hand-worm, also cheese-mite or itch-mite. It is hence stated in at least one excellent modern English dictionary, that ciron was the *Acarus scabiei* or itch-mite. Ciron is given as early as 1530 as a hand-worm, and again in 1611; while, according to Sir William Aitkin, "Moufet, in his *Theatrum Insectarum*, first mentioned the itch insect in a particular manner in 1663." Moreover, the early references to the ciron all speak of it as a worm. Cooke, of Warwick, for instance, in 1685, defines "sirones" to be "pustules in the palms of the hands or soles of the feet, having little worms in them;" and he directs that the worms, "having been pickt out with a needle, the parts are to be washt with the decoction of oak leaves and alum, or sulphur with tartar" (while he mentions the itch in a different place without referring to its parasitic nature); and Urquhart, in his *Rabelais* (1693), speaks of the ciron-worm. The earlier writers on the itch insect did not depict it as a worm, but as an insect with six legs, and it does not seem to have been regarded as a mite or worm at all until 1812, when the French apothecary, Galés, defrauded the Academy of Sciences out of the prize it offered for the demonstration of the existence of the itch insect by concealing common cheese-mites under the nail of his thumb, and dextrously producing them as he pricked the pustules of itch patients, representing them to be the veritable itch-mites. There are only two other parasites to which it is possible to refer the ciron—namely, the guinea worm and the chigo or jigger. The latter (the *Pulex penetrans*) is found in the West Indies as well as in America; it burrows in the soles of the feet, and may possibly have been known as early as

1530, though this is hardly likely. It has been given to it by an American zoographer (Morse) in 1796, this very name of ciron, but possibly by error. The guinea-worm (the *Filaria* or *Dracunculus medientis*) is declared by Hirsch to have been well known to the ancients; but he adds that Galen (who had never seen a case) believed it to be an affection of the veins, and not a worm; and that subsequent writers were misled by this and similar opinions into believing that the so-called dracunculi were portions of altered tissue, and not living entities at all. It appears, however, that as early as 1674, Welsch had disproved this belief, and shown that the disease was caused by a parasite. It is not improbable either that cases of guinea-worm had been observed in sailors returning from Egypt to Europe, and, being supposed to be a disease other than dracunculiasis, the parasite may have thus received the French name "ciron." The communication between the French Mediterranean ports and Egypt make this the more likely. Be this as it may, however, it is probable that Sloane, in his "Jamaica" (1725), is speaking of the dracunculus when he says of the chigo, that "if taken out like a ciron there is no harm." On the other hand, Sir M. Hales, in 1677, speaks of the "acarus, cyro, or hand-worm," while Dr. Henry Power, in 1664, evidently refers to the acarus in his experimental philosophy, where he speaks of "whey-worms, called by some wheal-worms or burrows." It is therefore probable that more than one parasite was included under the name "ciron."—*Ibid.*

SUBCUTANEOUS LYMPHORRHAGIA.—Dr. Neufeld mentions in a Polish journal a few cases which have come under his notice, where, in consequence of some injury, extravasation of lymph from a lymphatic vessel has occurred. Six years ago a man was brought into the hospital who had been struck on the thigh with a large piece of coal. There was no discoloration of the skin, but there was marked fluctuation over a large portion of the anterior and lateral aspects of the thigh. Some years later another patient came into the hospital who had received a blow on the back; here also there was extensive fluctuation involving the whole of the dorsal region. With regard to the first case, although Dr. Neufeld suspected from the first that the fluctuating fluid was lymph, he was unable to feel certain of it, and up to that time no description of lymphorrhagia had been published in any of the well known text-books. As the tumor showed no signs of diminishing after a couple of months, he made an extensive

incision into it, thus emptying the sac, after which the wound healed rapidly without fever. In the second patient the fluid disappeared spontaneously after the patient had been lying on his back for six weeks. A third case is mentioned in which no change took place for six weeks. Dr. Neufeld is disposed to agree with Gussenbauer as to the origin of this accident, and believes that the best treatment consists in laying the sac well open during the first few days.—*London Lancet*.

**ACTION OF COCAINE ON THE BODY TEMPERATURE.**—As interesting as those chemical bodies which reduce temperature in the febrile state are those which when introduced into the bodies of animals or of man produce fever. It is possible that the investigation of the action of these fever-producers may lead to some clearer ideas than we have at present on the influence of central nervous system on heat production and heat loss. According to Ott and Colmar, peptones and albumoses, when introduced in sufficient quantity into the circulation of the blood, cause a rise of body temperature by affecting the cerebral heat centers. We may, therefore, have a "peptone fever." Mosso, in an elaborate paper on cocaine, published last year, showed that cocaine also increased the body temperature; and he considered it the most energetic body yet known that possesses this action. Curiously enough, he found that although chloral hydrate antagonized many of the physiological effects of cocaine it did not counteract the febrile action, a result all the more astonishing since one of the most marked effects of chloral is to reduce the body temperature. Reichert, in a recent communication to the *Universal Medical Magazine*, has further experimented with cocaine. He found that in dogs a dose of 0.0025 gram of hydrochlorate of cocaine per kilo of body weight raises the temperature  $0.2^{\circ}$  to  $0.5^{\circ}$  C., while a larger dose, 0.02 gram per kilo, causes a rise of  $4^{\circ}$  C. There is, however, no direct relation between the dose of cocaine and the effect on the body temperature; small doses may have a greater effect than large, and *vice versa*. With large non-fatal doses, however, the temperature may remain high for as long as eight hours; so that we have not merely an evanescent rise of the temperature, but the development of an actual febrile state. As in the case of peptone, section of the medulla from the spinal cord prevents this action of cocaine. The effect is therefore on the heat centers in the brain. Calorimetric investigation showed that there

was increased heat production at first, followed by increased loss of heat. If the animal were curarized, however, it was found that instead of the increase of production there was an increase of loss of heat; so that curare in this respect seems to antagonize the effect of cocaine.—*British Medical Journal*.

**THE RESPIRATION CHAIR IN EMPHYSEMA AND ASTHMA.**—In a graduation thesis Dr. Carl Grunert, of Halle, discusses and describes the treatment of emphysema and asthma by means of the respiration chair. The chair is so constructed as to effect by means of levers and bands attached to it pressure and traction on the thorax similar to that exerted by the muscles in forced respiration. A cuirass makes backward and downward pressure on the thorax, while a broad band compresses the abdomen and so increases the intra-abdominal pressure; the abdominal viscera then force the diaphragm upward, and the latter rises. The ultimate effect, according to the author, is to make a forced expiration possible, to considerably decrease the volume of the thorax, and to empty more completely the hitherto badly aerated alveoli, so that at the next inspiration more oxygen enters; any bronchitic mucus which may be occluding the alveolus is also expelled. This is followed, of course, very soon by diminution of the dyspnea. The disturbance of the circulation of the blood in consequence of emphysema is recognized by the abnormal loudness of the second pulmonary sound. This was found to decrease in three patients after a treatment of from three to six weeks in the respiration chair, while the first mitral sound increased, showing that the cardiac muscle had become stronger. Emphysematous patients treated in the chair lost more or less completely their chronic bronchial catarrh; the attacks of coughing improved greatly, permitting sleep to be obtained without disturbance; the asthmatic symptoms too were frequently cured. A number of cases treated by this method in the chair are described, and the results obtained tend to show that in many instances the respiration chair may prove an advantageous method of treatment.—*London Lancet*.

**A NEW SYMPTOM OF PERICARDITIS.**—In some cases the diagnosis of effusion into the pericardium is difficult; and a symptom, first noticed by Bamberger, is said to be constantly present, and to aid materially in arriving at a correct conclusion. Puis, in the *Wiener medicinische Wochenschrift*, early in this year, has again attracted attention to

the point. By percussion of the patient in a sitting position, or when lying on the right side, there is a muffled tympanitic resonance or diminished resonance over the left side of the thorax behind, extending downward from the angle of the scapula; and at the place of greatest loss of resonance there is distinct bronchial breathing and bronchophony, with increased vocal fremitus. If the patient is made to bend forward, a portion of the dullness completely disappears, another portion becomes tympanitic, and no bronchial breathing is heard. This change is more marked still if the patient assumes the knee-elbow position. The physical signs observed are ascribed to compression of the lower lobe of the left lung by the fluid in the pericardium, and is found chiefly in young adults with chests which are elongated or narrowed antero-posteriorly. The presence of pneumonia or pleuritis is contraindicated by the alteration of the physical signs when the position of the patient is changed.—*British Medical Journal*.

**DIPHTHERITIC PARALYSIS.**—The general impression about the prognosis of diphtheritic paralysis used to be that it was not very unfavorable. But the labors of some of the members of the medical staff of the Great Ormond-street Hospital go to show otherwise. In children the affection is by no means one on which the physician can look with a satisfied gaze. The paralysis brings in its train a fatal possibility, chiefly from three directions: heart, lungs, and larynx—the organs whose innervation is largely by the vagus and phrenic nerves, the motor fibers of which are derived from nerve cells in the anterior horns of the spinal cord or their equivalents in the floor of the fourth ventricle. Dr. Harry Swift's pamphlet will serve to extend the knowledge of the prognosis of diphtheritic palsy on the continent of Australia. The work is constructed in excellent form, and contains many observations made by the author, while one of the resident medical officers at the Great Ormond-street Hospital. The mode of disappearance of the knee-jerk, as described by Dr. Swift, differs from that observed by Dr. Angel Monev, who made out an increased excitability of this phenomenon prior to its final extinction. Dr. Herringham also discovered a similar excessive irritability of the deep reflexes during the period of restoration of the knee-jerk. The long absence of the knee-jerk in cases of post-diphtheritic debility unattended by actual paralysis is a fact on which Bernhard first laid proper stress. The knee-jerk is one of the most delicate indicators of the state of

the nervous system, and some small muscles come, perhaps, next to it in sensitiveness—for example, the neuromuscular apparatus of the ciliary muscle, the pupil, and the ocular muscles. Cases of complete ophthalmoplegia have been recorded as the outcome of diphtheria.—*London Lancet*.

**A CASE OF LEPROSY APPARENTLY ARRESTED.**—As this subject is attracting attention at the present time, I think the further history of a case of leprosy, in which the disease appears to be arrested, may be of interest. In the *Journal* of June 28, 1879, I published the following account of a man suffering from this disease:

"T. M. was born in and spent his youth in England. After residing twenty-four years in Jamaica he returned to London in November, 1877. He noticed the first symptoms of his disease in May, 1878, when large patches of discoloration appeared on his legs followed by smaller spots on the face and arms. A tonic treatment was first employed, and in September, 1878, chaulmoogra oil in small doses was given, which was increased to 20 minims three times daily. This he continued to take till March 10, 1879, when I first saw him. He stated that his condition improved when he commenced to take the oil, but the complaint recurred in a more marked degree.

"On March 10, 1879, he presented the following appearance: He was hale and well nourished. There were dusky-red, raised patches, two or three inches in diameter, scattered over the face, neck, body, and limbs, with the characteristic leonine expression of countenance and thickening of the ears and of the tissues in the positions occupied by the spots. A superficial ulcer existed on the outside of the left leg, and one spot on the right thigh; and the fusiles of the feet, from the great toes to the heels, were anesthetic.

"I directed him to take chaulmoogra oil in dram doses thrice daily. The only inconvenience he experienced was slight constipation, which an occasional mild purgative removed. He has continued the same treatment. The ulcer on the leg rapidly healed. When I saw him a week ago the spots had faded in color, and lost much of their thickening, while some had disappeared, and the anæsthesia was less marked, and his general health had improved.

I have kept this man under observation at the Hospital for Diseases of the Skin, Blackfriars, ever since. He continued to take the oil in diminishing doses, and to ap-

ply it freely to his skin till within the last year or so. His symptoms gradually became less marked, the areas of anesthesia contracting, and the discoloration of the skin slowly fading. He has experienced no recurrence. When I last saw him, toward the end of 1888, there was no evidence of his having had the disease, except a slight brownish staining of the skin of the backs of the hands, and some loss of sensation about parts of his legs and feet. His general health was excellent. He has resided all this time in the suburbs of London. I saw his wife and daughter, and they are neither of them affected with the disease.

I have tried the same treatment in other cases of leprosy without success, but no other patient of mine has been able to take such large doses of the oil. This man took it in 90-minim doses at one time.

This case seems to me interesting on several grounds: (1) As showing that the disease may seemingly be arrested in an early stage, the patient living in London; (2) that the disease did not mend till he took full doses of chaulmoogra oil; (3) that, like Mr. Hutchinson's case, in which the progress of the disease apparently ceased, the complaint was consequent on residence in Jamaica.

The evidence has long appeared to me to point to leprosy being primarily dependent upon an organism which is associated with decomposing organic substances, such as fish or flesh, and is introduced into the body with the food.—*Dr. Wyndam Cottle, British Medical Journal.*

**INDICATIONS FOR IRIDECTOMY AND SCLEROTOMY IN GLAUCOMA.**—*Dr. Loshechnikoff*, writing in an ophthalmological review published at Kieff, gives a *resume* of two hundred and eighty-four sclerotomies performed by him while attached to the ophthalmic clinic in Moscow. The operation employed was Wecker and Mauthner's double sclerotomy. There were eight cases of acute glaucoma, sixty-eight of chronic glaucoma from inflammation, ninety-three of absolute glaucoma, seventy-one of incipient, and eleven of simple glaucoma. To each series is added a table of effects on tension and sight. The effect is called "excellent when T (tension) becomes normal or less than normal and central sight increases; "good" when T decreases and V (vision) remains the same; "medium" in cases of *status quo ante*, or when V is somewhat worse, but T decreased, or when there is a little improvement of V with permanent T; "bad" when V is worse and T permanent. In table iii, which deals with absolute and degenerative

glaucoma, the author often says, "V improves," "V remains unaltered," though we are accustomed to use the expression "absolute" only in complete blindness from glaucoma. The author, however, claims for this series the best results, no less than eighty-two per cent. The following are some of his conclusions: Iridectomy is indicated in chronic and subacute glaucoma. In absolute glaucoma, with symptoms of degeneration, sclerotomy is indicated. In acute glaucoma sclerotomy is a preliminary operation, to be followed generally by iridectomy. Sclerotomy is for the sake of appearance preferable to iridectomy, and holds out better prospects for the improvement of sight. It is consequently indicated in incipient glaucoma. In simple glaucoma sclerotomy is preferable. In all cases of imminent prolapse of the vitreous, and especially in congenital hydrophthalmus, sclerotomy is indicated. In secondary glaucoma iridectomy is always preferable. It is absolutely necessary to use eserine before sclerotomy.—*London Lancet.*

**PRECANCEROUS CONDITIONS OF THE MUCOUS MEMBRANE OF THE BLADDER RECOGNIZABLE BY ELECTRIC LIGHT.**—It is generally admitted that precancerous conditions of the tongue, mammary areola, and prepuce do exist and are recognizable. I believe that in some instances the mucous membrane of the bladder may be observed by means of electric light, to pass through a similar stage. Usually the first indication of a well-developed vesical tumor is an attack of painless hematuria; but this is not always so. Out of twenty-five cases of vesical growth which have been under my observation during the last eighteen months—since the introduction of the incandescent lamp cystoscope—two cases, which I repeatedly but vainly examined for vesical tumor, awoke in my mind suspicions as to the probability of a precancerous stage existing. In both instances my surmises were justified by cancer subsequently developing. In three other cases recently examined, presenting symptoms of growth but in which no tumor could be discovered, I have been forced to give a most guarded prognosis on account of the appearance of the mucous membrane.

In nearly all these cases a certain amount of residual urine (not of prostatic origin) was present, and a painless profuse hematuria was observed. The mucous membrane over the posterior wall behind the interureteral bar was blurred, lumpy, and gelatinous. I have pointed out that this is the situation at which vesical cancer commences,

and I have good reasons for believing that the irritation of residual urine is sometimes a causative factor in its production.—*E. H. Fenwick, British Medical Journal.*

**THROAT DISEASE IN MAN AND THE LOWER ANIMALS.**—Another suggestion as to the existence of a connection between diphtheria and allied throat disease in the human subject and some similar disease in a lower animal comes from Darton, near Barnsley, where Dr. Bruce Low, of the Local Government Board, is making inquiry as to the deaths of twenty children from diphtheria and so-called "croup." The clerk to the Local Board of Health has reported that in a number of cases there seems ground for believing that the disease had been communicated to children by means of cats which were ailing, one of them fatally so. Whatever the actual facts in this case may turn out to be, it is quite certain that we already know enough to call for much greater caution than has heretofore been observed in our dealings with animals such as cats, and also with certain birds, when these appear to be suffering from throat affections.—*London Lancet.*

**SYPHILIS COMPLICATED WITH SCURVY.**—Dr. Talysin, having under his care two cases of syphilis complicated with scurvy, and finding no mention in literature of the best treatment of the two diseases when occurring simultaneously, resolved, after a consultation with his colleagues, to treat the syphilis alone. The mercury given, though it soon produced a formidable degree of cachexia, was continued for about a month, by which time the syphilitic affection had entirely disappeared. Only then was the scurvy treated. It was cured in about six weeks by the administration of quinine and acids combined with strengthening food.—*Ibid.*

**ADDITIONAL NOTE ON THE TREATMENT OF YELLOW FEVER.**—Dr. George M. Sternberg, Surgeon U. S. A., writes to the Therapeutic Gazette for June as follows:

I have just received a letter from Dr. Reuben Cleary, an American physician practicing in Rio, in which he says, "In all I have treated thirty-four cases of yellow fever, all of them genuine, but as about one half did not present albumen in the urine nor black vomit, they might be contested, yet they all began with sudden chilliness, then excessive temperature, mostly with dry skin (temperature 39.9° to 40.5°), which lasted from twelve to seventy-two hours, abating somewhat; tongue white-yellowish, skin yellow, great hyperemia of the thoracic integument, some diminution of the

urine, gastric uneasiness, and vomiting. In my opinion and that of an experienced Brazilian physician they were undoubted cases of yellow fever. Of the thirty-four, I lost only one—that is the one I wrote you about—and in every case I used your formula steadily throughout. In one case I gave three liters. I found it better to use three centigrams of the mercuric bichloride, and gave it in one or two doses, ice cold. I also controlled the heat with antipyrin or antifebrin, and gave appropriate medicaments for gastric and other symptoms as they presented themselves."

Dr. Sternberg's prescription is as follows:

Sodii bicarb.....grams x (grs. 150);

Hydr. chloridi cor. centigr. ii (gr. 2);

Aqua pura.....liter i (1 quart). M.

Sig: 50 grams (about 1½ oz.) every hour; to be given *ice cold*.

This Dr. Cleary has modified thus:

Bichlor. hydrag.....03;

Bicarb. sodii.....10;

Aq. pura.....1,000. M.

Sig: Dose, two large tablespoonfuls every hour, *ice cold*.

**THE RETINA IN ANEMIC CONDITIONS.**—Dr. Arthur Friedrichson, of Dorpat, has published as an inaugural dissertation a set of observations made with the ophthalmoscope on patients with anemia, chlorosis, and other general diseases. He finds that in chlorosis and in anemia consequent on hemorrhage the ophthalmoscope reveals either no morbid change at all or merely a certain amount of hyperemia of the retinal vessels. The transparency of the retinal vessels appears to depend upon the amount of hemoglobin contained in the blood, but it is especially well marked when there is at the same time a diminution in the number of the red corpuscles. When the anemia is due to hemorrhage, and also in chlorosis, the pulsations of the retinal arteries have the appearance of being mainly "locomotory" movements, whereas in the anemia of neurasthenic patients they present very frequently that of changes in the caliber of the vessels. Dr. Friedrichson found the appearance known as Hufschmidt's progressive venous pulse very frequently in valvular disease of the heart.—*London Lancet.*

**THE DIURNAL AND NOCTURNAL EXCRETION OF URINE.**—However we may appreciate the truth of certain theories, do we not too often fail to carry them into practice, and this often on account of our natural laziness or the inconvenience incurred to others. Take the examination of urine as an example. We advise the patient or applicant for life insurance to

bring the urine of the night, or a part of the total quantity passed in twenty-four hours. As a fact we may at times, with the assistance of a good nurse, be able to secure the urine as we want it from an actual invalid: but with the majority of life-insurance applicants the urine is generally the most difficult thing to procure, and we are glad to get it from any part of the day or night. As a fact, also, this makes a great difference. Aside from the risk that the day urine may be affected by nourishment taken, or may contain albumen from any alcoholic, other factors affect it.

Sir Wm. Roberts has shown that in healthy individuals the solid diurnal excretion is, per hour, twice as great as the nocturnal, and the liquid is four and a half times as great. Excretion is more active during the day than during the night in health, while in disease, as Claude Wilson (*Lancet*, June 29, 1889) has pointed out, the nocturnal rate of excretion is always found to be increased, and is often even greater than the diurnal.

Such careful examinations of the urine can only be carried out with any measure of success in hospitals, but such investigations are of great value, and should be still further pursued, as they tend to give us a clearer insight into many obscure diseases in which an ordinary examination of the urine has hitherto yielded little or nothing.—*Maryland Medical Journal*.

**LACTOSE AS A DIURETIC.**—Prof. Germain Sée has made a long communication to the Academy of Medicine on the employment of lactose in the treatment of diseases of the heart, the conclusions of which may be summarized as follows: Lactose constitutes the most powerful diuretic, and, at the same time, the most inoffensive. It is lactose alone which gives to milk its diuretic property. The other principles of milk, particularly the water and the salts, have no manifest or useful action; the chloride of sodium adds nothing to the polyuria due to the sugar of milk, and the salts of potash themselves play only a very limited part. Milk, taken in doses of two liters, produces diuresis; but in doses of four liters, each of which contains 50 grams of lactose, it determines also a very pronounced glycosuria, a transitory diabetes, a portion of 200 grams of sugar thus absorbed being eliminated by the urine. There is likewise a considerable excretion of urea, indicating a destruction of the albuminates. There is, then, at the same time, glycosuria and azoturia. The use of sugar of milk obviates these inconveniences and dangers; 100 grams of lactose in a mixture produce an enormous diuresis, which may not be obtained with four or five

liters of milk. With lactose there is neither glycosuria nor azoturia. In milk the action of lactose is impeded by the caseine and fat. Lactose acts with certainty in dropsies of cardiac origin, but in a doubtful manner, or even has no action, in dropsies of renal origin. In affections of the heart it fails only when the kidney becomes granular and when the albumen rises to sixty centigrams or to one gram per liter. So long as the albumen remains in this minimum proportion the result is favorable. Lactose is in general well supported, whereas milk is not always acceptable to patients. Lactose has another great advantage over milk in permitting patients to take all kinds of nourishment, as it does not overload the stomach as milk does. Prof. Sée considers that we have, in lactose, the diuretic of affections of the heart at the astyolic period, and the true curative means of dropsies of cardiac origin, even those which have resisted all other polyuric agents; but it is powerless to relieve the dyspnea resulting from heart disease. It should, therefore, be seconded by the iodide of potassium, the remedy *par excellence* for this complication.—*London Lancet*.

**NEW BLOOD TEST FOR POISONING WITH CARBONOUS OXIDE.**—Katagama gives, in *Virchow's Archiv*, Bd. xiv, Heft 1, a new blood test for poisoning with carbonous oxide (CO). This test depends upon the fact that blood containing carbonous oxide, after the addition of orange-colored ammonium sulphide (sulphur, parts 2.5; colorless sulphide of ammonium, parts 100) and acetic acid becomes a beautiful bright red; whereas normal blood is turned a greenish-gray or reddish-green gray. The test is performed in the following manner: 1 cubic centimeter (15 minims) of the blood to be investigated, is diluted with 50 cubic centimeters (13 fluid drams) of water, and of this mixture 10 cubic centimeters (160 minims) are put in a test tube; first two tenths of a cubic centimeter of orange-colored sulphide of ammonium, then two tenths to three tenths of a cubic centimeter of thirty-per-cent acetic acid are added, and the closed test tube inverted a few times.—*Weiner Med. Presse*.

**THE TONSILS IN PHTHISIS.**—Dr. Dmochowski publishes in a Polish medical journal, the *Gazeta Lekarski*, some important observations on the condition of the tonsils and the follicular glands at the base of the tongue in phthisical subjects. Strassmann had previously made some observations on the tonsils, and had found them affected in thirteen cases out of twenty-one which he examined. Dr. Dmochowski was able to show some affection of the tonsils

in every one of the fifteen cases examined *post mortem*, the lymphatic glands at the base of the tongue being also affected in nine of these cases. The lungs were in every instance decidedly affected, and in five there was slight tuberculous ulceration of the larynx. The ages of the subjects varied from eighteen to fifty-six. Presumably the tonsils were infected from the mouth, the bacillary infection at first affecting the epithelial layers and subsequently the deeper tissues, viz., the lymphatic sinuses and the follicles themselves. The tuberculous character of these changes was made manifest either by the existence of large disseminated collections of Koch's bacilli or by the concomitant signs of general inflammation of the connective tissue, or by the occurrence of fully developed tubercles. These showed themselves first of all in the connective tissue between the follicles along the lymphatic vessels leading to neighboring cervical lymphatic glands. Ulcerations of the tonsils were observed in the crypts, but never on the free surface of the glands; sometimes cavities were found in the tonsils. In the living subject no marked affection could ever be detected by the naked eye in the tonsils. The absence of disposition to external ulceration is explained by the supposition that the deeper tissues form a far more suitable soil for the development of the tubercle bacilli than the superficial tissues, that is, the mucous membrane covering the surface of the gland.—*London Lancet*.

**MENTHOL IN ASTHMA.**—Dr. Jores mentions, in the *Therapeutische Monatshefte*, that he has employed menthol with success in asthma. The patient was a woman who had asthmatic attacks for which all the usual remedies had proved unsuccessful. Jores then resorted to menthol, a twenty-per-cent solution in olive oil. While before its use there were crackling and rattling râles heard in the lungs, the whole attack disappeared after a few inhalations, and auscultation showed that respiration was entirely normal, the heart-beat unchanged, the pulse full and strong. The patient said that she frequently felt in her head as though she had inhaled chloroform. Since its first employment the remedy has proved promptly successful in all attacks.

**MELON-SEED BODIES IN JOINTS AND TENDON SHEATHS.**—Considerable light has recently been thrown by Schuchardt (*Medical News*) on the mode of production of these bodies. They either consist really of altered portions of the lining membrane of the walls of the cavity itself in which they are contained, or they are developed in connection with the tendon sheaths,

while a careful examination of them shows that coagulated fibrin does not really enter into their composition. In more than one instance the living membrane of the joint was found to be covered with a viscid substance more or less laminated in character, and here and there already causing adhesions to take place between the opposing surfaces of the joints. These glutinous masses appear to be composed of partially "necrosed" portions of the joint wall, which, instead of passing away, remain connected with the wall and likewise become attached to one another. The movements of the surfaces of the joints upon each other then cause these bodies to drop into the joints, where they lie loose, as melon-seed bodies, and if the joint is in a fairly healthy condition, they may be evacuated and leave behind a good and useful joint.—*Medical Standard*.

**A LARGE LYMPHOMA OF THE NECK.**—S. T., a female, thirty-three years of age, was admitted to the hospital with a very considerable enlargement of the cervical lymphatic glands on the left side, which gave her considerable uneasiness, not only by reason of the deformity, which was very great, but by the embarrassment of movement, by impeding the respiration, and by the constant sense of fatigue from pressure on and displacement of the muscles. As the growth was increasing, and with it all the symptoms, operation was decided upon. A long incision was made from the mastoid process nearly to the supra-sternal notch, the flaps turned back, the external jugular vein divided between two ligatures and the mass of enlarged glands exposed. They were found adherent to the internal jugular vein with such firmness that it could not be separated by the fingers, and a careful and minute dissection was necessary to free it. This was successfully accomplished, and after the ligation of a few venous and arterial trunks the whole growth was removed. Careful drainage was employed and the flaps united rapidly and satisfactorily.

A cardinal rule in removing growths of this character, and indeed in the extirpation of all growths of the neck, is one which has been laid down many years ago by Dr. Agnew in his clinical lectures to the University class, namely, thoroughly and completely to expose the tumor and then to work directly upon its surface, completely dividing all the structures, muscular or fascial, external to its capsule. If these two essential points be borne in mind if the tumor is first freed at a point where its relations are least important, if the deeper dissections are carried on as far as possible with a blunt director or with the fingers, and if the knife when used is kept turned as much as possi-

ble toward the surface of the tumor, many formidable growths may be removed with comparative ease and safety.

The description of the above case would apply almost without the change of a word to another upon which I have recently operated, except that the growth, which occurred in a boy five years of age, was both relatively and absolutely larger. In this case also there were adhesions to the internal jugular, which, as Mr. Holmes has pointed out, is the vessel most likely to be involved. I was fortunate in both cases in being able to remove the growth without injury to this vessel, but would not hesitate to divide it between two ligatures, if any portion of it were found hopelessly adherent or actually incorporated with the tumor.—*J. W. White University Magazine.*

**HEMORRHOIDS: WHITEHEAD'S OPERATION.** G. S., forty three years of age, seven months previous to admission had a severe attack of biliary colic terminating in a copious hemorrhage from the bowels. This was shortly followed by the development of a circular mass of hemorrhoids protruding from the anus at each stool, bleeding profusely and causing considerable pain and annoyance. The following operation was performed on October 31st:

The patient being etherized and placed in the lithotomy position, the sphincters were paralyzed by digital stretching, the thumbs being introduced into the anus, back to back, and then carried forcibly toward the tuberosities of the ischium, the dilatation being thus made as complete as possible. The hemorrhoids with the whole area of mucous membrane giving rise to them, the so-called "pile area," were thus made to prolapse, after which the mucous membrane was completely divided just within its line of junction with the skin, the "white line" of Mr. Hilton. The membrane was then carefully separated from the external and internal sphincters by means of scissors aided by dissection with the fingers, the separation being effected close to the surface of the muscles. In this way the whole circle of mucous membrane, bearing with it the hemorrhoidal tumors, was freed from its connections until it could be drawn down outside of the anus. It was then divided circularly just above the upper limits of the piles. This division was made by means of scissors, and in sections of about one third of an inch, each portion so cut being immediately stitched to the free edge of the divided skin. It was begun at the posterior or lower margin of the anus, so that the area of operation should be as little obscured by blood as possible. It was carried around the whole circumference of the bowel in this manner, so that when the opera-

tion was complete not only the hemorrhoids, but also that portion of the mucous membrane of the lower part of the rectum in which they originate, were entirely removed. A circular wound was left, the free edges of the skin and mucous membrane being united by stitches as after circumcision. A few vessels required to be twisted, and one or two ligatures were applied. Carbolated silk was used for the stitches.

The wound was dusted with iodoform. A suppository of one half grain of extract of opium was inserted into the rectum; a compress of salicylated absorbent cotton dusted with iodoform was placed against the anus and a T bandage was applied; the patient was kept in bed in a supine position; the bowels were confined by means of opium and concentrated diet for a week, after which a dose of castor oil was given. There was no fever and but little pain. Union by first intention followed through the whole wound. Most of the silk sutures were discharged at the time the bowels were opened, and the patient's cure was complete in about twelve days.

Mr. Whitehead has now performed this operation more than three hundred times, not only without a death but without abscess, incontinence of urine, stricture, or any alarming symptoms having occurred. It is claimed that the operation is not only less dangerous and less painful but also much more thorough than the old operations by the ligature or by the clamp and cautery. It is thought that by removing all that portion of the mucous coat of the bowel in which the veins have become enlarged and weakened that the possibility of recurrence is done away with. On the other hand, it is stated in favor of ligation that no blood whatever is lost, while hemorrhage seems more likely to occur after excision; that no fresh raw surface is exposed in a region which it is very difficult to keep aseptic; that the results are almost if not quite as good, and that the danger of subsequent stricture of the lower end of the rectum or anus is considerably less, at least in cases in which an entire ring of hemorrhoids is not ligated. Whitehead's operation may be said still to be on trial before the profession. I may add, however, that the only case of stricture at the anus which I have seen lately, resulting from an operation, followed the ligation of a hemorrhoidal mass which completely encircled the anus. As to statistics, it is undoubted that there are occasional deaths from tetanus following the ligation of piles. I know of three unreported cases which have occurred in this city alone. It remains to be seen whether—as large numbers of practitioners adopt and perform the Whitehead operation—its statistics will remain as good as at present.—*Dr. J. W. White, University Magazine.*

# The American Practitioner and News

"NEC TENUI PENNÂ."

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D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } - - - Editors.

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JOHN P. MORTON & CO.  
440 to 446 West Main Street, Louisville, Ky.

1807. JOHN P. MORTON. 1889.

John P. Morton, one of the best known men in Louisville, and the oldest bookseller in the United States, died at his home in this city, on Friday, July 19th, aged eighty-two years.

Mr. Morton was born in Lexington, Ky. At the age of sixteen he came to Louisville to shift for himself. His bent was in the line of books. He loved books—he loved to read and to handle them. He soon found employment with W. W. Worsely, the chief bookseller here, and before his majority became manager of the concern. The firm name was, not long after, changed to Morton & Smith. This house published a daily paper, *The Focus and Journal*. Later the paper was called *The Louisville Journal*, and George D. Prentice came from his New England home to edit it. The present *Courier-Journal* is a continuation of that publication.

In 1838 Mr. Henry A. Griswold, whose sister Mr. Morton had married, was admitted a partner, under the firm name of Morton &

Griswold. In 1858, Mr. Griswold having engaged in other pursuits, the title of the house was changed to John P. Morton & Co.

In 1870 they undertook the publication of the *American Practitioner*, a monthly journal of Medicine and Surgery. Subsequently they issued the *Louisville Medical News* a weekly journal, under the editorial control of Richard O. Cowling, M. D. The success of both these journals is largely due to the active interest taken in them by John P. Morton himself.

Mr. Morton was a man of large brain, advanced views, and strong purpose. His face, always handsome took on with advancing years that refinement of line and expression which grow out of faith, hope, courage, patience, charity, and truth.

Mr. Morton loved flowers and young people. He was fond of birds and dogs. He spent much time with the first. He made pets of the latter.

When a mere youth he was ill in a distant town among strangers. While on his sick-bed he determined, if the means ever came to him, to make provision for the care in Louisville of persons situated as he was. The means came, and out of them has grown *The Church Home and Infirmary*, a beautiful structure, dedicated to the homeless and the sick—a munificent gift, whose cost is well-nigh \$200,000.

Mr. Morton was interested in all charitable work, but that which touched him most related to the orphan and the sick. He made provision in the *Infirmary* for the care of the one. He gave in a princely way for the help of the other. He was a leading man in the Episcopal Church. His life was sweet and sound—its end peaceful, its steadfast companion and devoted helper, who was Miss Harriet Griswold, survives him.

## Notes and Queries.

**THE TREATMENT OF BURNS.**—For superficial burns of the face, Dr. Christopher Heath recommends (*London Lancet*) a mixture of collodion, one part, castor oil, two parts. He says it does not set firm like ordinary collodion, but it sets sufficiently to hold its place and to protect the skin from the air, which is the great point, and at the same time without any injurious or uncomfortable pressure upon the part.

Nitrate of silver (ten grains to the ounce) also makes a good application. It smarts a good deal at first. It acts by forming a little superficial eschar all over the burnt surface, and in that way protects it from the air.

When vesication has been produced, the vesicles should be opened in a dependent portion, the serum let out, carefully preserving the cuticle, and then carbolic oil applied. Boracic ointment is another good dressing, and has the advantage of being greasy and being to a slight extent aseptic.

When eschars have been produced, time must be allowed for the sloughs to come away. It is all-important to preserve the patient from the risks of pyemia. For this purpose absorbent and antiseptic dressings should be used. Carbolic oil may be applied next the surface, and over that plenty of cotton-wool, in order to absorb the fluid. When an extensive surface has been burnt, it is good to dust a little iodoform upon them. Poulticing for twenty-four hours will not do any harm, especially if a little iodoform is sprinkled on them when sloughs are slow in separating. When they have come away, or have been picked out with forceps or snipped off with scissors, a large granulating surface will be found beneath, which may be more or less healthy, or may be somewhat flabby and require the use of stimulating lotions.

**SIR SPENCER WELLS ON CREMATION.**—The *London Lancet* says that Sir Spencer Wells deserves credit for the pains he takes to disseminate a knowledge of the arguments for cremation in Great Britain, and of the success which this method of disposing of the dead meets with. It is impossible to deny the

strength of the arguments in favor of cremation as a most effective and prompt way of reducing the body to its mineral elements, which process, the *Lancet* says, can be carried out now at Woking at the small cost of ten shillings per body. Sir Spencer Wells argues that however light the covering of the dead body, its burial in earth is objectionable, for the reason that infective germs are in this way preserved and carried about by water or air, to operate injuriously when favorable meteorological or social states occur. The rapid growth of population, and especially of urban populations, due to a greater prevalence of peace and a more satisfactory sanitary system, invests this question with ever-increasing importance. The religious objections have been completely answered by men like Lord Shaftesbury and Bishop Fraser. There is evidence that the number of cremations is increasing in Italy and England, as in the week preceding Sir Spencer Wells' speech there had been three cremations at Woking; while in Italy, in the three years, 1886, 1887, and 1888, there were 119, 155, and 202. Dr. Parkes thinks that for maritime nations much is to be said for burial at sea; but we are a long way off such a solution of a very serious question, which strangely underates the sentimental objections.

**AN EXPLORING CANULA FOR SOLID TUMORS.**—In a paper read at a recent meeting of the Gynecological Society of Boston, Dr. J. Collins Warren advocated the use of a little instrument devised by Dr. S. J. Mixter. It consists of a fine canula with a sharp cutting edge. It is used as follows: An injection of cocaine is first given; then with a tenotome a puncture is made through the skin, and through this the canula is thrust into the tumor to be explored; it is then withdrawn half an inch, its direction altered, and a second thrust made. It is afterward wholly withdrawn, one finger being placed over the outer end. By this means a small mass of the tumor is removed, from which sections can be at once cut on the freezing microtome, or later on after hardening. Specimens of a tumor an inch or more in length and an eighth of an inch in diameter can be removed in this way,

and may afford ample material for microscopic investigation. The instrument is designed to assist in the diagnosis of the earliest stages of scirrhus of the breast, or of any conditions in which the microscope alone can lead the surgeon to a definite decision as to the nature of a solid mass. Dr. Warren, an accomplished surgeon, spoke highly of the instrument, and pointed out that by it the pathologist could obtain a specimen of the whole depth of a tumor—not of its central parts merely—and of the surrounding tissues, showing the mode of its invasion by the neoplasm.

**ORIGINAL INVESTIGATION.**—The Vermont Microscopical Association has just announced that a prize of \$250, given by the Wells & Richardson Company, the well-known chemists, will be paid to the first discoverer of a new disease germ. The wonderful discovery by Prof. Koch of the cholera germ, as the cause of cholera, stimulated great research throughout the world, and it is believed this liberal prize, offered by a house of such standing, will greatly assist in the detection of micro-organisms that are the direct cause of disease and death. All who are interested in the subject, and the conditions of this prize, should write to C. Smith Bynton, M. D., secretary of the Association, Burlington, Vt.

**TREATMENT OF AN EXPERT WITNESS.**—The American Lancet, June, 1889, says that Dr. W. H. Mays, of San Francisco, Cal., was lately summoned as an expert to San Bernardino, a distance of a thousand miles. He was compelled to leave his business, regardless of the injury to his interests and those of his patients. Called to the stand, he was ordered to testify without fee, and upon refusing he was committed to jail. Let it be remembered he was not summoned as a witness to facts of which he was cognizant, but as an expert, to give the court the benefit of his knowledge and skill in unraveling the intricacies of a certain case. At this distance, it seems to us that justice, in this case, was the worst of tyrants. We trust that the doctor and his friends may be able to change the ways of California courts. The

matter being placed before the California State Society, as one man it decided to make Dr. Mays' case its own and contest the matter to the end.—*Med. and Surg. Reporter.*

**DANGERS FROM CONSUMPTIVE FELLOW-TRAVELERS.**—In the illustrated Medical News, March, 1889, p. 294, attention is drawn to the danger run from traveling with consumptive patients. There is strong evidence that on board ship it is very easy for husband and wife to communicate the disease to one another. It is even possible for a healthy person to become consumptive if sharing the same cabin as any one known to have the disease. On board ship there is often a great deficiency of fresh air, and the cabins are badly ventilated, to say nothing of the danger of taking the poison from the upsetting of utensils which contain sputum. The danger of traveling with infected fellow-passengers in a railway carriage or public conveyance may be so infinitesimal as practically to be neglected, yet when one is brought into contact with an infected individual for a considerable length of time, and more especially when the air which the infected and non-infected individuals are forced to breathe is neither large in quantity nor good in quality, the danger is undoubtedly a real one, and it is to be hoped that means will be taken to prevent the spread of so fatal a disease in this manner.

**THE TAMPON IN THE DIAGNOSIS OF CHRONIC ENDOMETRITIS.**—Dr. B. S. Schultze, Professor of Gynecology in the University of Jena, says that he has found of value in the diagnosis of chronic endometritis, during a number of years, a tampon of absorbent cotton, freely soaked in a twenty to twenty-five per cent solution of tannin in glycerine and firmly pressed in the vaginal vault, previously carefully cleaned, so that the mouth and vaginal portion of the cervix are completely covered. The glycerine in the tampon draws the water freely from the surrounding tissue. The formed constituents of the uterine secretion will not, or only to a slight degree, be floated over the place at which they come in contact with the tampon. If the tampon is removed after twenty-four or forty-eight hours, there is found on it, if the uterus is en-

tirely healthy, only a small quantity of cervical secretion, clear as glass. If the mucous membrane in a section above the mouth of the uterus is affected with catarrh, there is found, besides on the tampon, pus which has come from the uterus.—*Medical and Surgical Reporter.*

**WELL-WORDED WISDOM.**—The *Lancet*, in commenting on the evils of overcrowding in the cities and the remedy, says: "Social problems are very difficult, and many well-meant efforts aggravate the mischiefs which they are intended to relieve. But if political economy teaches us to beware of plausible propositions and to put no faith in specifics, it must not persuade us to sit with folded hands and idly to lament evils which all recognize. At the worst we can probably do some good and hasten in some small degree the advent of that time of 'sweeter manners, purer laws' of which the Laureate sings."

**ANTIPYRIN IN LOCOMOTOR ATAXIA**—Dr. A. P. Buchman, of Fort Wayne, Indiana, writes to the *New York Medical Record*, May 25, 1889, as follows: "I have had under my care a case of locomotor ataxia in which the 'lightning pains' were unusually severe. The chest constriction was most agonizing. Fortunately, I gave a ten-grain dose of antipyrin, with the result of putting my patient at complete rest within an hour. Since then he keeps himself supplied with a quantity of ten-grain antipyrin capsules, and whenever, especially at night, the pains become annoying, one, or at the most two capsules secure a whole night's sleep. I began the use of the antipyrin about the first of March; my patient has not missed a single night's rest since then."

**PYLORECTOMY.**—On June 26th Sir William Stokes performed the operation of pylorectomy in the Meath Hospital on a female patient, aged forty-eight, suffering from cancer of the pylorus. This is said to be the third case in which this formidable procedure has been adopted in the United Kingdom, Mr. Southam's and Mr. McArdle's cases having been the

first and second. The operation in Sir William Stokes' case lasted over two hours. The patient subsequently rallied fairly well, and continued to progress satisfactorily up to 9:30 P. M. We regret to learn that she then became alarmingly weak, and, notwithstanding the efforts that were made to revive her, the weakness continued to increase, and at 11 P. M. she became collapsed, and died at 11:35 P. M., just twelve hours after the operation. The statistics of the operation so far are not encouraging, for, of seventeen cases operated on for pyloric disease, there are said to have been only four recoveries.—*British Medical Journal.*

**SALOL IN CHOLERA.**—Professor Löwenthal, who has lately made experiments on the action of salol in cholera bacilli in Professor Cornil's laboratory in Paris, has received a special mission from the French Government to proceed to Tonquin in order to study the effects of salol on cholera patients. Professor Löwenthal is for this purpose nominated a navy medical officer *à titre d'étranger*, but is allowed full liberty of action. This is the first time that the French Government has selected a member of another nation for such a post, and it well indicates the tendency of science to draw nations nearer together.

**THE McDOWELL MEDICAL SOCIETY**, with Dr. E. H. Luckett, President, and Dr. J. J. Rodman, Secretary, met June 7th in the city hall, Owensboro, Ky. The attendance was very good, and the meeting, as usual, very interesting. For the next meeting, at Henderson, October 10th, Dr. J. E. Pendleton, of Hartford, was elected President, Dr. John Y. Brown, of Henderson, First Vice-President, Dr. W. E. Fowlkes, of Calhoun, Second Vice-President, and Dr. S. S. Watkins, of Owensboro, Secretary.

**MERCK'S BULLETIN** for June, 1889 (delayed a few weeks in publication), contains a highly valuable table of maximal doses—by grains and grams—for one hundred and thirteen of the newer remedies, for the majority of which no reliable dose limits have hitherto been published in this country.

THE perils of book reviewing were exemplified in a suit brought in a London court, about a month ago, against the publishing firm of MacMillan & Co. for an alleged libel consisting of a review of Dr. Herbert Tibbits' work on *Massage and Allied Methods of Treatment*, which appeared in *Nature*. The review was a caustic one, and in it occurred this sentence: "Any one even slightly acquainted with the subject will at once perceive that its writer, while professing to teach massage, has not mastered the first principles of the subject." The plaintiff claimed \$5,000 damages. The jury awarded him one farthing, and the judge refused him his costs.—*Journal American Medical Association*.

**ELIXIR VITÆ.**—The Maryland Medical Journal says: When Brown-Séquard's rejuvenator has been more fully investigated by others, it will then be time enough to become enthusiastic over it. Such remedies can be taken and absorbed by the stomach. Our menus will have a new course for old men, and this new dish will probably be as palatable as the much loved thymus and pancreas.

[Yes, yes, my dear Mr. Editor; but did you never hear of lamb fries and mountain oysters?]

A CERTAIN Dr. Sequitz, of New York, has been so much impressed with the fact that the spread of consumption is largely due to marriage between tuberculous couples, that he has prepared and sent to the health board of that city a long communication urging the passage of a law that would prohibit the marriage of consumptives.

**AMERICAN PUBLIC HEALTH ASSOCIATION.** The preliminary announcement is out of the American Public Health Association, which holds its seventeenth annual meeting at Brooklyn, N. Y., October 22, 23, 24, 25, 1889. Among the *desiderata* we notice that "all papers must be either printed, type-written, or in plain handwriting."

THE recent Legislature of Texas voted \$50,000 for the establishment at Galveston of a medical branch of the State University.

DUKE CHARLES THEODORE, of Bavaria, a skillful ophthalmologist, is winning the affection and esteem of many of Bavaria's poor by his gratuitous services in their behalf. His wife, the Duchess, is his able assistant, and performs the part of nurse and general benefactor.

THE AMERICAN RHINOLOGICAL ASSOCIATION will hold its seventh annual meeting at Chicago, Ill., August 28, 29, and 30, 1889. The Committee on the Examination of the Innates of Insane Asylums will make their report on the Relation of Rhinal Inflammation to Mind Affections at this session. DR. R. S. KNODE,  
OMAHA, NEB. *Secretary.*

Since the above was put in type we have received the following from the secretary: Owing to the absence of a number of the Fellows of the American Rhinological Association in Europe, and to the Pacific Coast, the annual meeting will be postponed until October 9, 10, and 11, 1889, at which time it will be held at the Palmer House, Chicago, Ill.

DR. H. MARION SIMS and Dr. Henry C. Coe have been elected professors of gynecology at the New York Polyclinic. Dr. Coe has also been appointed surgeon to the New York Cancer Hospital.

THE tapeworm had become a general form of malady in Servia; but much was done last year to get rid of this by careful sanitary precautions being taken by the veterinary staff, in examining the swine and pork imported from other countries.

RECENT news from Madras indicates that that portion of the world is ravaged both by famine and cholera. The province of Ganjam, on the Bay of Bengal, is where the epidemic has reached its greatest intensity. The official figures put the deaths at one thousand per week from cholera.

THE American Pharmaceutical Association lately met in San Francisco, with an attendance of three hundred and seventy-five delegates.

**COCAINE AS A HEMOSTATIC.**—The Paris correspondent of the Journal of the American Medical Association says: An anonymous writer in the Scalpel on the hemostatic action of cocaine remarked, that for the last three years he had recourse to the subcutaneous injections of the hydrochlorate of cocaine to produce local anesthesia, that after these injections there was no hemorrhage, or at least the flow of blood was less than when he did not employ cocaine. From this fact the idea struck him that it would be a useful means against excessive hemorrhages, which are sometimes difficult and long to arrest. With the view of correcting the flow of blood, the author tried the direct application to the bleeding surface of pads of charpie imbibed in the following solution: Hydrochlorate of cocaine, one gram, alcohol, five drops, laurel-cherry water, five grams. He sometimes applied the powder of cocaine to the wound, at others he employed a subcutaneous injection of the same substance in the neighborhood of the seat of hemorrhage. The first mode of application succeeded in rapidly arresting a severe attack of epistaxis. Suppositories containing from fifteen to twenty centigrams of cocaine have always succeeded in arresting persistent oozing of blood. Commenting on this note, Dr. Fano, in the *Journal d'Oculistique*, observed that this latter dose of cocaine is not without danger. It is very well known with what facility and rapidity is accomplished the function of absorption in the rectum.

**JAPAN** has thirty-one schools of medicine, four schools of pharmacy, and two schools of veterinary surgery. At this rate the "Jap" profession will soon be in as bad a condition as Uncle Sam's.

**A COUNTY MEDICO-CHIRURGICAL SOCIETY** was organized at Carrollton, Carroll County, Ky., July 8th, with fifteen charter members. The Society will meet again August 19th, and once a month thereafter.

B. LOGAN HOLMES, M. D.,  
Secretary.

**THERE** are one dozen negro physicians in Brooklyn.

**A GERMAN** Odontological Society has recently been organized in Berlin under the presidency of Professor Busch. It will hold a general meeting and five scientific sittings every year.

It is stated that Dr. Horace Mason Perkins, formerly of Higham, Mass., has been promoted to be guardian of the young Emperor of China.

**THIRTY-ONE** persons at Findlay, Ohio, were poisoned on June 22d by eating corned beef, and it is thought some of the cases will terminate fatally.

**CAIRO** (Ill.) has erected a handsome monument to the memory of Dr. Roswell Waldo, at Mound City, in recognition of his services in the yellow fever epidemic in 1878.

**A CHINESE** leper was discovered in the Sacramento jail recently. He had been sent there from Folsom for refusing to pay a poll tax.

It is estimated that there is one leper to every forty of the inhabitants of the Sandwich Islands.

**DR. J. LEWIS SMITH, jr.**, son of Dr. J. Lewis Smith, died suddenly in New York.

### SPECIAL NOTICE.

**OFFENSIVE ODOR OF THE BREATH** due to bad teeth or other causes may be overcome, or at the least greatly abated, by the habitual use of *Listerine*. Add a teaspoonful to a tumblerful of water for a mouth-wash and gargle, and if a little is swallowed, so much the better. Indeed, a bad breath is not unfrequently caused by the gaseous eructations of indigestion, and for this also *Listerine* is an excellent remedy, in doses of twenty to thirty drops in a little water.—*Sanitarian*.

*Katharmon Chemical Company, St. Louis, Mo:*

**GENTLEMEN**—I am well pleased with your "Katharmon," have had excellent results from its use. Quite recently I had an opportunity of testing its detergent and antiseptic properties in a case of Burn covering a large area, with most gratifying results. In acute Rhinitis and Follicular troubles of the Nose and Throat it has proven satisfactory in my hands. Its safety, simplicity, and reliability especially commend it. Yours respectfully,

F. C. COLLIER, M. D.

SWEET SPRINGS, Mo., July 12, 1889.

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÆ."

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[NEW SERIES.]

*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.*—RUSKIN.

## Original Articles.

### THE LOCAL USE OF ICE OR COLD IN THE TREATMENT OF BURNS.\*

BY J. G. CARPENTER, M. D.

The subject of burns is a most interesting one: first, because of the suddenness of the traumatism and the co-existence of pain and shock to the nerves and nerve centers, and the intense reaction which follows; second, the destructive lesions of inflammation with suppuration, ulceration and sloughing; third, the disease of erysipelas, blood-poisoning, pneumonia, bronchitis, and ulceration of duodenum, which often attend burns; fourth, the scars and deformities, the sequelæ of burns. It may be well said that the physician who can arrest pain, subdue shock and prevent or arrest inflammations accompanying burns without the use of opiates and anesthetics, is entitled to all praise, and is indeed a blessing and benefactor to the human family. In the local use of ice and ice-water *per se*, there is the anodyne, anesthetic, antiphlogistic, and astringent, the *sine qua non* of therapeutics in the treatment of burns.

On the 4th of February, 1881, Mr. J. A. R. was scalded from the nape of neck and shoulders to the gluteal regions by a stream of hot, mushy, distilled slop: fortunately the back was protected to some extent by a coat, vest, shirt and net-shirt, or the burn might have been much more serious.

There was the first stage of burn, characterized by redness, heat, pain, and the second stage, by tumefaction, vesication, with destruction of the cuticle, with erosion—the latter representing so many oases in the area of the burn.

As the pain and shock were so severe, morphine, gr.  $\frac{1}{2}$ , atropine,  $\frac{1}{16}$ , was given hypodermically in one hour. Patient was placed on his face, or sides as he desired; soft linen cloths, one third larger than the area of burn, were wrung out of ice water and applied to the burn, and changed every ten or fifteen minutes for twelve hours, then every hour or two for twenty four hours, then every two or three hours for twelve hours, and dispensed with; if not changed this often the pain and heat would return until within the last twelve hours they were applied. By the continuous use of cold this way the pain, heat, redness, tumefaction, phlyctenula, and exfoliation of the cuticle were subdued and inflammation controlled—in truth, the fire or inflammation was frozen out in forty-eight hours, and the patient virtually well of his burn; and in the oases of exfoliation of the cuticle the latter was sufficiently regenerated to leave no raw surface, and with the exception of some discoloration and remnants of old cuticle no trace of burn remained.

**CASE 2.** A newspaper was thrown into the grate by a little girl; on the paper igniting, the blaze extended outside of the grate and set the lambrequin afire, which was attached to the mantel. In this room was a very sick lady. An effort was made to smother the fire and extinguish it at once, and not get the patient frightened. In doing so the hands were burned severely. The burn was fortunately limited to the first and

\* Read before the Kentucky State Medical Society, May Meeting, 1889.

second stages. The hands and fingers were wrapped in two layers of bath-towel wrung out of ice-water, and a lump of ice—about a half pound—placed on the dorsal and palmar aspects of each hand; and when the ice melted it was replenished in lumps.

In nine hours from the commencement of the use of the ice no trace of the burn could be seen, no heat, pain, tumefaction, redness, exfoliation nor vesication nor raw surface; the serum of the vesicles was absorbed, and no vesicle wall left. The hands and fingers felt rough, as they would from fingering dirt or plaster-of-Paris. The cure was so complete and wonderful and sudden as to be magical, and one who has not tried ice or ice-water in the incipency of burns or scalds will be loth to believe the very favorable results; and in this audience there may be many doubting Thomases. This treatment has been verified several times by the writer.

Within the shortest time on reception of the burn the pain was very intense, but knowing the anodyne, anesthetic, antiphlogistic and astringent effects of cold, no opiate nor other anodyne nor anesthetic was administered than ice.

In both of these cases, as in other similar ones, patients avow no pain nor discomfort was felt so long as the ice or ice applications were changed at the proper intervals and used systematically. This question presents itself, viz., How does cold act? The physiological action of ice or cold, first, is to contract the constrictors of the vaso-motor nerves and diminish the amount of blood in the arterioles and capillaries; second, following this constriction of the vessels is a relaxation of the vaso-motor dilators and hyperemia. When cold has been unduly applied, the vitality of the parts is impaired and the physiological congestion becomes pathological, and an inflammatory process is established. But in the treatment of burns the cold is judiciously applied just sufficiently to give ease and comfort to the patient. When there is pain, increase the cold or ice applications—that is, make the cold more intense or change the applications

oftener, at shorter intervals. As the inflammation subsides use less and less cold; though it must not be forgotten that cold, unduly applied, is an irritant, a pain-maker, and that ice applied directly to even pathological conditions is painful; but when the parts are protected by sufficient layers of cloths, in acute and subacute congestions and inflammations, it is an anodyne, anesthetic, astringent, antiphlogistic and local tonic.

Cold, locally, is similar to the action of cocaine, in that it contracts the arterioles and capillaries, drives the blood from the parts affected, blunts or obtunds sensibility, and is both anesthetic and anodyne; and these effects can be continued indefinitely as long as the acute or subacute congestion or inflammation continues, and on subsidence of the latter the cold must be stopped. By this contraction of the blood-vessels by ice, in the treatment of burns, hyperemia and the other stages of inflammation are arrested or prevented, and ice is antiphlogistic. Through the anodyne, anesthetic, and antiphlogistic effects of ice local and general irritation is arrested and prevented, and excess of blood is drawn from the burn by the contraction of the blood-vessels. Ice is astringent, not only to the latter, but to all the tissues involved in the burn, and by holding the vessels in this contracted state becomes a local tonic.

Ice is not only indicated in the first and second stages of burns, but in all the stages contained in that most excellent classification of Dupuytren.

Authorities state the vesicles should be punctured in scalds or burns. This is doubtless bad practice, for the serum is lost and the blisters themselves become so many sores or wounds to be treated, as well as the other lesions of the burns. On the contrary, if ice or cold is used judiciously from the incipency, or the first one or two hours after the burn, the serum is absorbed and a cohesion takes place by adhesive inflammation between the vesicle wall, cuticle and *rete mucosum*, and the skin returns to its natural state. In burns where there is exfoliation of the cuticle, the oases of erosion through

the effects of cold do not suppurate. Ice can be used in conjunction with other measures that are aseptic and antiseptic in the other stages of burns, and the one supplements the other. In conclusion it may be said that in the use of cold the lesions of burns are kept in an aseptic condition.

STANFORD, KY.

## THE TREATMENT OF CROUPOUS PNEUMONIA.\*

BY ROBERT C. KENNER, A. M., M. D.

Quain says: "Our object must be to endeavor to conduct the pneumonia to a favorable termination. We can not arrest its progress, but we can often do very much both to maintain the strength of the patient and to modify those elements in the disease which tend to destroy life." This truth should deter us from any attempt to abort the disease by any means calculated to depress the system, and in that way diminish the power of resistance on the part of the patient.

It is important that the sick-room should be light and properly ventilated. Juergensen says: "In my opinion patients who are exposed to the light make the best recovery;" and evidence of the prejudicial effect of dark rooms is abundant in the writings of all good observers. The light should not fall into the face of the patient, but the bed be placed in such a position that without annoying him he can obtain its cheering and tonic influence. The temperature of the room should not be allowed to fall below 60° F. nor rise above 65°. A thermometer should be hung in the room and strict attention given to this matter. When the temperature rises above the desired point the top of one or two windows can be let down, and desired mean in this way may be secured. I find it often serviceable to leave the top of a window permanently down; but the same purpose can be frequently secured by leaving open a door that does not communicate directly with the external air. Prof. Loomis wisely advises that adults be allowed to regulate the temperature of their own rooms.

The bed clothes should be suited to supply comfort to the patient. It will be difficult often to get children to lie in bed, and they will cry to stay in the nurse's or mother's arms. In such cases it is important to caution the nurse against allowing the feet to be exposed. Attention to this and other details is of the greatest importance, since failure to observe them is frequently followed by severity in all the symptoms, and often relapses when convalescence was thought to be fairly established. The chest should be incased in cotton batting and this covered with oil-silk or flannel. This affords a needed protection from draughts, promotes diaphoresis, and tends greatly to the comfort of the patient. I have these put on in such a way that I can have counter-irritants applied without a great deal of trouble. Turpentine liniment every three or four hours often contributes to the relief of pain, and the same may be said of ammonia liniment, and many things of that class. Poultices are often harmful. Especially is this true if we have other than a very attentive nurse, who would allow them to become cold. Blisters are recommended by Loomis to be used in the third stage in the hope of expediting the removal of the exudation. Yet I never use them in this stage because I believe their employment affords us no good results, but often gives the patient great annoyance. Yet their use in the first stage is often attended with the most marked benefit in relieving the pleuritic pain so often present. I have found them valuable, and use them in all cases where the pain is a feature that racks the patient considerably. Of course, where the blisters are used the batting jackets are not to be used.

Much has been written lately advocating a return to the practice of Wood and Watson, and the older writers, of bleeding in pneumonia. Hartshorne, of Philadelphia, has advocated this means, and has brought the statistics of several hospitals to show that when bleeding was an essential factor in the treatment that more patients recovered than under the present treatment. These statistics are not valuable for many reasons—firstly, they are not large, they do not attempt to correct the physical conditions of the patients at the time

\* Read before the Louisville Clinical Association, June 1889.

of entrance, or state the amount of pulmonary involvement. Without going to other statistics for proof of the fallacy of Harts-horne's statements, these two points are sufficient to make his conclusions less weighty than they seem.

Bleeding is often useful to postpone asphyxia, and this is an indication for its use in pneumonia. Flint says that it is allowable in plethoric persons, but I think that there is a tendency on the part of this disease to depress the vital forces to such an extent that it is never advisable, unless as a means, as before stated, to avert for a time impending death from asphyxia. Wilson Fox sums up the present knowledge of bleeding in the following manner: "(1) That indiscriminate bleeding immensely increases the mortality of the disease. (2) That it is specially fatal in old people and young children, in patients of exhausted constitution, and in those suffering from chronic diseases, and particularly from Bright's disease. (3) That it is absolutely unnecessary in the majority of cases of young adults and also young children. (4) That in the majority of cases it has no influence whatever either in cutting short the disease, in lessening its duration, or in diminishing the pyrexia, but that occasionally these results appear to follow from its use when practiced early. (5) That in the majority of cases it hinders the critical fall of temperature and delays convalescence. (6) That in the majority of cases, as shown especially by Bennett's and Didel's data, recovery is equally if not more rapid when it is not practiced as when it is resorted to. (7) That in a few cases a moderate venesection may be necessary in the early stages to avert imminent danger of death from asphyxia."

For the first four days there is more or less pain. This, of course, varies in different cases and different individuals. In some it is very severe and agonizing, while in others it amounts to little more than an uneasiness. The use of opium is necessary during this time in such amounts as will secure freedom from pain and unrest. Sometimes the pain is so intense as to require the hourly administration of a quarter of a grain of sulph. morphine. Morphine given in this way is accompanied with no danger, but

on the other hand goes a long way toward preserving the strength of the patient, and of ultimately preventing "failure of cardiac power," which, as Quain truly says, "is the great source of danger." When the pneumonic infiltration is complete, which is usually about the fourth day, the pain is no longer a symptom, and further use of opium is not called for, and, of course, its use would be attended with positive harm should it be continued, because it might tend to paralyze the bronchial tubes and favor an accumulation of mucus in them.

One of the most important indications in the treatment of this disease is the proper use of stimulants. I regard nearly all cases which come under the observation of physicians as requiring the administration of stimulants. Their use is called for in such quantities and at such intervals as will give their weak pulse better volume. It is my practice, unless the patient impresses me as being positively plethoric, to begin the use of stimulants from my first visit, and have them continued. I am satisfied that by this means I have prevented many cases of cardiac failure. The amount and frequency of the administration will depend always on the urgency of the cardiac symptoms. In this connection Juergensen well says: "To lay down a set of rules for the administration of stimulants would be a very thankless task. Let the principles of treatment be mastered, and then quiet observation at the bedside will give one the experience which inspires confidence. A timely attention to the therapeutics of cardiac symptoms generally makes the use of heavy artillery unnecessary; but if we are obliged to bring this into the field, it should be borne in mind that it is unnecessary to place any limit to the dose of stimulants; if the weaker stimulants fail we must use the stronger, and increase the dose. In such cases the only limit is consistency; whoever is timid when life is at stake really belongs elsewhere than at the bedside."

I said that stimulants were indicated in nearly all cases. All practitioners meet some exceedingly light cases of pneumonia in which, it is true, we might get on without them; but I have observed that even these light manifestations of the disease progressed more favorably

when stimulants formed an essential part of the treatment. One great point to be remembered is, that stimulants are to be given often. Every two to four hours I do not consider often enough. A dose of alcohol will wear off entirely in two or three hours, but by giving it hourly, or even much oftener, we can keep up and obtain fully its good effects. I have never employed camphor largely, and can therefore add nothing as to its usefulness. Yet Jourgensen and several other great German observers are loud in its laudations. Just here let me quote the words of Robert Bentley Todd, since they bear directly on this point, and are the observations of one of the greatest observers who has enriched the literature of pneumonia. He says: "I would say that in all cases pneumonia has, independently of this or that mode of treatment, a decided tendency to depress the general powers of life—in some more, in some less." In this observation all who have observed the disease studiously will concur, and I think also in the deduction I propose to make, that stimulants are required in this and all diseases in which the vital forces are likely to be overwhelmed. The carbonate of ammonia has been advocated as a remedy, exerting in some way a curative influence on this disease, and at the same time serving us as excellent cardiac stimulants. Relative to its claims as a remedy having in some unexplained way a curative influence on croupous pneumonia, I take it there are no advocates to-day; yet, as a cardiac stimulant, expectorant, and diaphoretic, it is a remedy looked upon by many applicable in a large number of cases. Attentive study of the results of treatment of this disease in one's own practice with the carbonate of ammonia I do not believe will recommend great reliance upon the drug. Reports from time to time in medical journals of a large number of brilliant cures of different observers should not wed us to a treatment, if under our observation the treatment was barren of like results. It is a fact that carbonate of ammonia is inferior to alcohol as a cardiac stimulant—that its stimulating powers do not last long, and that it produces irritation of the stomach after prolonged use or its administration in large doses. This, as Prof. Leunis

says, would cause an interference with nutrition, and "in that way diminish the chances of recovery." For these reasons I have not for some time used carbonate of ammonia in this disease, except as an ingredient of a diaphoretic and expectorant mixture which I shall mention later on.

In all the forms of this disease it has become a matter of routine with me to give quinine at intervals throughout the active period of the disease. I generally order the sulphate in doses from two to three grains every four hours. This has appeared to exert a curative influence on the disease, which I suppose to be accounted for on the ground of its tonic action. While quinine is antipyretic in larger doses than this, it may be that even small doses like this prevent a high range of temperature. On the use of quinine Flint says: "Of tonic remedies, quinia is to be preferred. It is not indicated in mild cases, but whenever there are grounds for anticipating undue depression of the powers of life, it may be given and continued during the progress of the disease." When we suspect malaria as a complication, its use is imperative, and many good observers think its use in all cases, whether we suspect malarial complication or not, as good practice, since that poison often gives little evidence of its presence until its explosion in some of its characteristic forms.

A matter of very great importance is to give due attention to diet. A sufficiency of nutritious food and digestible food should be administered, and no neglect of this matter must be overlooked. Milk, soft boiled eggs, beef peptonoids, beef tea, animal broths are useful articles of diet. Milk, combined with lime-water, or treated with Fairbairn's peptogenic powder, is very useful when we are treating children, or when our patient is delicate. Nestlé's food, malted milk, and several other agents of this class are very useful. Prof. Leunis advises the administration of some grateful wine along with the food, not as a stimulant, but to increase the digestion. My experience is that wine of pepton given after food taking, is of value in that it assists the weakened digestive powers. Lactopeptine, or any article of known value, will act similarly,

The question, shall we use antipyretics in the treatment of croupous pneumonia? is an important one. A correct answer of this question can not be made until it is first settled to what extent fever is an element of danger, and whether the antipyretic at our disposal is free from danger. Many observers claim that fever, if it does not rise above  $103^{\circ}$ , is a conservative process. Also that in cases of typhoid fever, in which the temperature was normal or sub-normal, there were present all those symptoms we are in the habit of according to high temperature. Dr. Joseph T. Smith, in the course of an article on this disease in the *New York Medical Record*, when speaking of antipyretics, says: "Shall the elevation of temperature be controlled—when and how?" This opens up such a broad field, and one so filled with combatants—it opens up that vast subject, the treatment of fever, which in itself would demand a whole evening to give even an outline view—that we may be pardoned if we but glance at the question.

We indorse the opinions of Dr. Whittaker, as expressed by him when discussing the subject at the meeting of the American Medical Association, 1888: "The bacteria," he says, "are sensitive to heat;  $170^{\circ}$  F. attenuates the bacteria of Frankel in from twenty-four to forty-eight hours." This corresponds pretty well with the clinical history of a case of pneumonia. The fever may be the very agent destroying the disease. It has been observed that those were the most favorable cases in which the temperature was most pronounced. Danger is not on the part of the fever, but on the part of the heart, and the question is whether it is not the best plan of treatment to sustain the heart—let the fever alone; be content with small doses of antipyrine or antifebrin to do away with any evil effects of high temperature. Dr. Shattuck, at the same time, said: "During the past the influence of temperature in pneumonia has been overrated." He has discarded the systematic use of antipyretics in this disease. This then, if an essential fever, should be treated as such so far as high temperature is concerned. So long as it does not exceed  $103^{\circ}$  F. no harm is being done, and as a rule antipyretics should be withheld.

It is known that antipyrine and several other antipyretic remedies exert a depressing influence on the heart, and this organ, by their use, is more heavily laden, and therefore more likely to fail. Yet, when the temperature is above  $104^{\circ}$  and reaches  $106^{\circ}$ , it may be justifiable to give antifebrin. Yet I should not recommend such a course. If an antipyretic should seem imperative, I should depend first on sponging the body in tepid water; and if this failed to appreciably lower the temperature, I should administer quinine in antipyretic doses, as I regard it as less liable to depress the heart. All of these agents are to be given with caution and watched.

It must be our concern that all measures, of whatever nature, calculated to depress the heart are rendered inoperative. Failure of the heart is the most dreaded of complications, and allowing the patient to sit up when he is too weak must be one of the things that we caution our nurse to observe.

Digitalis is by some regarded as an essential remedy in this disease. Some writers have advocated the use of no other agent in the treatment of the disease. I believe, if close watch be kept on the heart, and alcoholic stimulants given properly, we will find no demand for digitalis. Flint recommends it when the heart becomes feeble and irregular. This is an indication for its use, but I believe it useless to resort to it as long as the alcohol will afford the same results, and it is my experience that it will never be needed when alcoholics are properly given. It is generally advisable to administer throughout the course of this disease a diaphoretic and expectorant; especially is this necessary if the skin is dry and harsh, or if there is much bronchitis present. A mixture containing syr. tolu, syr. ipecac, and carbonate ammonia serves as well in this connection, and I frequently administer it.

When the nervous symptoms are out of proportion to the other elements of the disease, good results may be had from musk. This remedy was insisted on in his lectures on pneumonia by Frossau, and will be found valuable.

Often the condition of the bowels will be a troublesome element in the disease. Where there is decided biliousness, much relief can

usually be obtained from the use of calomel and colocynth combined—frequently, however, the same results may be accomplished by the exhibition of sulph. mag., or other saline. There are other minor points of treatment which will come up for consideration, and which it is impossible to outline in the limits of this paper, and which the nature of the particular case must afford the judgment of the practitioner the proper mode of action. We shall always be in the right line of defense, and always do the proper thing if we bear in mind the Juergensen's words: "Nature cures, and the only duty of the physician is to maintain life until this cure is effected."

LOUISVILLE, KY.

## Reviews and Bibliography.

**A Text-Book of Pharmacology, Therapeutics, and Materia Medica.** By T. LAUDER BRIDGTON, M. D., D. Sc., F. R. S., F. R. C. P., Assistant Physician and Lecturer on Materia Medica at St. Bartholomew's Hospital, etc. Adapted in the United States Pharmacopœia, by FRANCIS H. WILLIAMS, M. D., Boston, Mass. Third edition; octavo, pp. 1261; leather. Price, \$1.50. Philadelphia: Lea Brothers & Co.

They who were fortunate enough to possess themselves of this great work in former editions need not be told that, taken for all in all, it is the most interesting treatise on therapeutics extant, and that in the arrangement of the matter relative to materia medica and pharmacology it sets things more readily to the physician's hand than any either of our great dispensatories.

The author is a master of condensation in book making, and, following a natural classification, puts into brief paragraphs what is known, and no more, of every remedial agent admitted to his pages. In therapeutics he follows strictly the physiological method, and brings into service a vast array of facts to show that there is a physiological reason for the administration of every drug and the exhibition of every measure that is worthy of trial in the treatment of disease.

It will be clear to the reader that the author has not yet succeeded in driving con-

servatism from the field, but it is equally clear that the author's method must be religiously followed if therapeutics is ever to rise to the dignity of a science.

**Therapeutics; its Principles and Practice.** By H. C. WOOD, M. D., LL. D., Professor of Materia Medica and Therapeutics, and Clinical Professor of Diseases of the Nervous System, in the University of Pennsylvania. A work on Medical Agencies, Drugs, and Poisons, with special reference to relations between Physiology and Clinical Medicine. The seventh edition of a treatise on Therapeutics, thoroughly rewritten and enlarged. Octavo, cloth, pp. 885. Price, \$6.00. Philadelphia: J. B. Lippincott & Co.

"A treatise on Therapeutics" by this able author has been, for many years, the favorite text book for student and hand book for practitioner in America. The present volume, though called a new edition of the above, is really a transmutation of it, being so radically changed that the reader would scarcely recognize in it his old therapeutic companion.

The first part of the book has been made last, and every chapter has been subjected to essential changes, necessitated by rapid growth in the therapeutic art and the introduction into the materia medica of many new drugs.

The admirers of the accomplished author will be glad to note that this flood of new remedies has not thrown him off his feet, but that he has exercised due discrimination in admitting them to his pages, where they receive the same wise, direct, and scientifically supported treatment accorded their predecessors in the years gone by.

**A System of Gynecology by American Authors.** Edited by MARCOUS D. MARSH, M. D., Professor of Obstetrics and Gynecology in the Medical Department of the University of Buffalo, N. Y. Vol. 81. Octavo, pp. 1180; leather. Philadelphia: Lea Brothers & Co.

This volume is made up of six chapters written by eight of our well-known American gynecologists and general surgeons. It discusses diseases of the female system

neuroses, extra-uterine gestation, tumors of the breast, diseases of the breast other than tumors, fistulæ, diseases of the bladder and urethra, non-malignant tumors of the uterus, malignant diseases of the uterus, laceration of the cervix, chronic inversion of the uterus, injuries and lacerations of the pelvic floor, the treatment of ovarian and of extra-ovarian tumors, diseases of the ovaries, diseases of the fallopian tubes, the pathology of ovarian tumors, the clinical history and diagnosis of pelvic tumors other than uterine and tubal, and displacements of the uterus.

The book is liberally and beautifully illustrated with wood-cuts and chromo-lithographic plates.

In a volume made up of so many excellent articles, from men each of whom is a master in his line, no part can be fairly selected for especial praise.

It was the design of the famous publishers in framing this great work to get into one systematic treatise all that the grand army of American gynecologists had to say upon this branch of medicine. That they are attaining their end the two volumes now published abundantly attest.

**A Reference Hand-Book of the Medical Sciences**, embracing the entire range of Scientific and Practical Medicine and allied Science, by various writers. Illustrated by chromo-lithographs and fine wood engravings. Edited by ALBERT H. BUCK, M. D., New York City. Vol. VI, pp. 778, royal octavo; leather. PRA—TEP. Vol. VII, pp. 795, royal octavo; leather. TER—WOR. New York: William Wood & Co. 1889.

Upon the issue of each of the five preceding volumes of this great work our reviewer has given our readers his opinion of each, with large prediction as to the prospective value of the completed work. With the seventh volume every topic embraced in the range of scientific and practical medicine and allied sciences is discussed in alphabetical order down to *worms*, presenting a vast collection of matter upon topics almost innumerable. What will be further discussed in the eighth volume, under the letter W, and what topics will be grouped under X, Y, and

Z, are matters upon which the learned and the curious may profitably speculate. The volume, it would seem, bids fair to be made up of medical "whims and additions," but of course it will contain a great chapter on yellow fever.

An analysis of volumes embracing so great a number of dissimilar topics can not be made, nor can their contents be practicably passed in review. It suffices to say that the articles are contributed by men of acknowledged authority in medicine and science, who give to the hand-book their best effort.

The work when completed will be a vast collection of medical and scientifically allied monographs, well written, well printed, well bound, and indexed to perfection.

## Correspondence.

### LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

At a meeting under the presidency of Mr. Edmund Kimber, Surgeon-General Sir William Moore delivered a lecture on Leprosy. In introducing the lecturer, the chairman referred to Sir William Moore's thirty years' medical experience in the East as entitling him to speak with the full authority of an expert on this painful subject.

After going briefly over the ground opened up during the recent leprosy scare in London, the lecturer observed that so far as this country was concerned he could not perceive any ground for uneasiness. There had always been a certain number of lepers in England, and would probably be more as communication with the East increased. At the same time it must always be remembered that our sanitary arrangements, although not attaining the excellence required by Dr. Richardson, were calculated to oppose the spread of any disease which required communication of the active germ by contact. Referring to the outcry which had been raised, that the Government of India should take immediate action with a view to checking the disease in that country, the lecturer showed that it was quite wrong to

suppose that nothing had been done in this respect in India, instancing particularly the work done in the leper asylums of the Bombay Presidency. He also showed the many difficulties lying in the way of any general isolation of lepers in India. Personally, he placed more confidence in the gradual spread of civilization and sanitation. At the conclusion of the lecture a resolution was carried expressive of the opinion "that the present scare on the subject of leprosy is unsupported by any extraordinary manifestation of the disease."

At present it seems only one fourth of the population reach three-score and ten, and only about 15 in 100,000 become centenarians. Dr. Robson Roose, in an article on "The Art of Prolonging Life," examines the problem. Dr. Roose observes, "Hereditary transmission is probably the most powerful factor in connection with longevity." A recent interesting example of transmitted longevity is that of the veteran guardian of the public health, Sir Edwin Chadwick, who was entertained at a public dinner a few weeks ago, on the occasion of his reaching his ninetieth year. He informed his entertainers that his father died at the age of eighty-four, his grandfather at ninety-five, and two ancestors were centenarians. Dr. Roose thinks that women are more likely to become old than men, which view is to some extent borne out by Dr. Humphrey's statistics. Of his 52 centenarians, 36 were women. Marriage would appear to be conducive to longevity. With regard to the learned professions, it would appear that among the clergy the average of life is beyond that of any similar class. The medical profession supplies but few instances of extreme old age, and the average duration of life among its members is decidedly low, a fact which can be easily accounted for. Broken rest, hard work, anxieties, exposure to weather and to the risks of infection can not fail to exert an injurious influence upon health. Wealth does not necessarily favor long life. In Professor Humphrey's Report on Aged Persons, containing an account of 824 individuals of both sexes, between the ages of 80 and 100, it is stated that 48 per cent were poor, 42 per cent were in comfortable circumstances, and only 10 per cent were described as being in affluent

circumstances. The author quotes some strange fancies which people have harbored as to agencies which tended to lengthen their days. A Mrs. Lawson, who died aged 106, instead of washing, smeared her face with lard, and asserted that "people who washed always caught cold." This lady was fully persuaded that she had discovered the universal medicine. Dr. Roose divides the whole term of life into the three main periods of growth and development, of maturity, and of decline. Diminished conservative power and consequent triumph of disintegrating forces are the prominent features of the third period, which begins at different times in different individuals, its advent being mainly controlled by the general course of the preceding years. The climacteric lies between forty-five and sixty, the period beyond belonging to advanced life or old age. In order to prolong life and at the same time to enjoy it, the doctor considers occupation of some kind is absolutely necessary, but no kind of strain must be put upon the mind by a person who has reached sixty-five or seventy years. As to the use of alcoholic liquors, Dr. Roose says it is not advisable that a man sixty-five or seventy years of age, who has taken alcohol in moderation all his life, should suddenly become an abstainer.

Bacteriology seems likely to benefit by the Eiffel Tower. A series of careful experiments are about to be instituted with a view of ascertaining the kind and relative number of micro-organisms permeating the air at various periods, not only at the top of the big tower, but also at its base, and at other specified levels.

Antipyrine in doses of from ten to thirty grains, administered twice a day, is strongly recommended by Drs. Havill and Hall in the preventive medical treatment of "hay fever," and "hay asthma." In a recent paper upon the subject Dr. Hall states that the principle above named "has recently been found very efficacious," and he points attention to there being every prospect of an unusually abundant hay crop, and a consequent probability of these distressing affections being very prevalent.

The medical officer who, in connection with the Local Government Board, has been investigating the cause of a number of deaths

from croup and diphtheria, which have occurred recently in Barnsley, has found in several instances the disease has been communicated by cats going from house to house.

"The Elixir Vitæ Discovered at Last," might well be the title of a remarkable memoir submitted to the French Academy last month by one of its most distinguished members, M. Brown-Séquard. Arguing upon preconceived and carefully-worked-out data, the well-known inquirer was led to put his hypothesis to the test of actual practice, and the results obtained with small animals were so promising that the researches were extended to the human body. In brief, they amount to this, viz., that a very small quantity of healthy liquor seminalis, when hypodermically injected into an aged or a feeble subject, speedily restores more or less of its pristine youthfulness to the same. Full details of this marvelous discovery are as yet of course kept back, the learned scientist contenting himself by stating that in his own case his legs ceased to totter beneath him, and he felt as if quite thirty years younger than he really was. As the subject is to be duly inquired into by a committee, with the view of disproving or confirming M. Brown-Séquard's results, it is necessary to have patience before it will be known if it is possible to recruit our army with "young soldiers" from Chelsea Hospital.

A daily paper states that many people are not a little disturbed by Dr. Kidd's article in the Nineteenth Century on Lord Beaconsfield's last illness. They feel that if all the details of one's mortal maladies, and the acts and utterances of the death-bed are to be printed by our medical men for general circulation, a new terror is added to death.

Last year there were no less than one hundred and fifty English and American graduates at the Vienna Medical School.

LONDON, July, 1889.

### PARIS LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

The question of the relations between syphilis and rachitism in infancy, was discussed at the Congress held in London during 1881, when the late Professor Parrot, who introduced

the subject, expressed an opinion opposite to that generally entertained in the profession. This opinion was thus formulated by him: "Rachitism knows no other origin than hereditary syphilis." Dr. Y. Comby, Physician to the Children's Hospital in Paris, recently published a note in which he endeavored to refute the arguments set forth by Dr. Parrot in the following terms: (1) Pathological anatomy teaches that rachitic lesions differ from syphilitic lesions. Rarefaction (spongoid tissue) characterizes rachitism, condensation (hard osteophytes), and ramollissement (gelatiniform atrophy) are special to syphilis. (2) Clinical observation shows that the two diseases behave in different ways, and sometimes in a manner opposed to each other. The cicatrices of the buttocks, the dental lesions common to syphilitic subjects, are exceptional in rickety subjects, the corneal lesions are almost always scrofulous; lingual desquamation has nothing syphilitic. (3) The traditional therapeutics of rachitism, which, far from being favorable to syphilitic subjects, are prejudicial to them, which is a protest against the assimilation attempted by Parrot. (4) Etiology finishes the ruin of the system. Rachitism is not known in many countries ravaged by syphilis. The poor pay to rickets a tribute heavier than that paid by the rich, although both are equal before syphilis. The causes of rachitism reside nearly altogether in the defective alimentation of infants, artificial feeding, coarse and premature alimentation, too early and too abrupt weaning, etc.

Dr. Comby proposes the following theory: (1) Rachitism is frequent in children affected with hereditary syphilis, but it is not on this account of a syphilitic nature. It is by wasting and cachexia, not by a specific influence, that hereditary syphilis ends in rachitism. By preventing this cachexia, or combating it by the mercurial treatment, and by a natural, exclusive, and prolonged lactation, would at the same time effect the prophylaxis of rachitism. Artificially fed, the little syphilitic subjects may be said to be doomed to rachitism. (2) As regards acquired syphilis, its action is equally free from all specificity. If contaminated children are provided at the proper

time with good treatment and a good wet nurse, they will escape rachitism more surely than in the case of hereditary syphilis. When they are deprived of these they become rickety. In any case syphilis acts only as a predisposing cause and as an adjuvant. It does not deserve, in the etiology of rachitism, a better place than any other infantile disease (measles, smallpox, scarlet fever, broncho-pneumonia, typhoid fever), the intervention of which may produce rachitism.

Some time ago a young girl, wearing an imitation tortoise-shell comb made of celluloid, was working near a stove very strongly heated, when suddenly her head became surrounded by flames which were rapidly extinguished, but which produced severe burns. On examination it was found that it was the comb of the child that got inflamed, and there was no trace of it left. An inquiry was held, and from a report made by Mr. Léon Fancher to the Council of Hygiene, it results that celluloid, which is manufactured with paroxylated paper treated by alcohol, then mixed with camphor and submitted to considerable pressure, is very combustible. Its combustion takes place with very great vivacity at a temperature of  $240^{\circ}\text{C}$ . Moreover, celluloid may be decomposed in a sudden manner under the action of heat, and the temperature at which this spontaneous deflagration takes place is comprised between  $170^{\circ}\text{C}$ . and  $180^{\circ}\text{C}$ . for the white celluloid, or that which contains no coloring matter, and does not rise above  $205^{\circ}\text{C}$ . for opaque celluloid, which contains a white substance made of zinc and divers coloring matters. The deflagration is always very active, almost instantaneous, and does not appear to be accompanied by light, as in the case of the ordinary cotton powder, but this circumstance is doubtless due to the abundant disengagement of rutilant vapors, accompanied by thick, black smoke, resulting from the deflagration. The conclusion of the report is, that all the articles in celluloid, so numerous in bazaars, are susceptible of spontaneous deflagration at a temperature of about  $200^{\circ}\text{C}$ ., and it is probable that, owing to the overheated air which surrounded the stove, the comb, which was in the child's hair, was suddenly submitted to a temperature of

$200^{\circ}\text{C}$ . which caused the spontaneous deflagration of the celluloid. This substance is therefore considered most dangerous, and consequently it was proposed that the manufacture of celluloid should be absolutely interdicted. Although M. Léon Fancher was the reporter of the inquiry, yet he did not concur in the opinion of the other members of the commission. He stated that the temperature of  $200^{\circ}\text{C}$ ., which is necessary to determine the deflagration of celluloid, is not met with, in the ordinary conditions of domestic life, in easy contact with woman's dress. There must have been a particular combination of circumstances to produce the accident above mentioned. That which proves it is, that since it took place, which is some years ago, notwithstanding the extreme diffusion and always increasing number of articles in celluloid, it has been impossible to find any mention, in any country whatever, of a similar accident. It was therefore considered unnecessary for the police to take rigorous measures against the articles which, although easily inflammable, do not present any very grave dangers. It is sufficient for the population to be made acquainted with these dangers to guard themselves against them.

Dr. F. Schwartz about a year ago read a note at the Société de Chirurgie on the treatment of leucorrhœa by boric acid. Having obtained excellent results from boric acid in powder in atorrhea, the author was induced to employ the remedy in the same manner in leucorrhœa. In the first case all the known remedies were employed, but with absolute non-success. With the boric acid, however, the patient was completely cured in fifteen days. The author has since employed this remedy in cases of leucorrhœa, and always with the same favorable results. He has therefore thought it necessary to bring it again to the notice of the Society. The following is the mode of procedure adopted by Dr. Schwartz: A vaginal irrigation should be practiced with water as hot as the patient can bear it. A speculum should then be introduced into the vagina, which is to be dried with sponge and absorbent cotton. This is to be followed by the introduction of boric acid in powder in sufficient quantity to fill the posterior part of the vagina and to com-

pletely cover all the intra-vaginal part of the uterine neck. The powder should be kept in its place by means of a large tampon of absorbent cotton. This dressing should be left in for three or four days, when it should be renewed if necessary, which is rarely the case. On the first two days there is still a slight watery discharge through the powder and the cotton, but it disappears promptly. Without wishing to set up boric acid as a panacea in all cases of leucorrhea, the author would strongly recommend this mode of treatment in this almost intractable affection.

In a former communication to the Academy of Sciences, MM. Brown-Séquard and d'Arsonval endeavored to prove that the toxicity of expired air depended on a toxic principle contained in that air. The authors have since made other researches, and have demonstrated by experiments on animals that death by inhalation of the poison which expired air contains is not hastened by the emanations of the vapors proceeding from the urine and the fecal matters of the animals submitted to this inhalation.

PARIS, July 26, 1889.

### VIENNA LETTER.

Since leaving London and coming to the Continent I have seen much of interest in the medical line. At Brussels, by a card from Prof. Roosa, of New York, I met Prof. Detstanche, who treats nothing but the ear. His methods of examination, etc., and many of his instruments are peculiarly his own. He holds his mirror in his mouth while making his examinations. He can consequently neither ask nor answer questions at this time. He keeps thirty or forty eustachian catheters in a kettle of boiling water, which is a very safe method against infection. He has a small, ingenious pump of his own, to which is attached a tip which fits in the external auditory canal, and by alternately exhausting and forcing air into the canal one can massage the middle ear, which is said to give in some cases of non-suppurative inflammation of that organ very good results. The treatment is old, but the in-

strument is new. I found Prof. Detstanche very kindly disposed.

At Berlin I met Profs. Krause, Frankel, Hartmann, and Hirschberg. The latter has his office, residence, hospital, and clinic for out-patients in one and the same building. The doctor speaks English perfectly, and showed me a great deal of attention. He is a thorough believer in antisepsis. He cooks his own bandages, cotton, and instruments, and uses absolute alcohol and solutions of carbolic acid profusely. He has an operating-room fitted up as perfectly aseptic as it can be made. He has specially constructed ovens in which to prepare his bandages, etc., attends himself to his instruments and his cases after operating. He gets excellent results. Others who are less careful say they get as good. When I asked him how he accounted for this, he replied, "I only account for my own." I find the teachers on the Continent exceedingly careful and patient. I can not understand how busy men can give so much time to teaching. They devote several hours to this work each day in the week except Sunday. They spend but little time in their offices, each day from one to three hours. Profs. Frankel and Hartmann were exceedingly attentive. They seemed to fear I might be neglected while in Berlin.

Prof. Krause, physician to the late Emperor of Prussia, greeted me as if he had known me all my life. By his request I lectured upon, and illustrated before his class at the Poliklinik, the O'Dwyer method of intubation. I spoke in English, and he followed in German. The students were much interested in the subject. Dr. Krause said tracheotomy statistics for diphtheria in Berlin made a very unfavorable showing. The results in intubation seemed to surprise him. He stated that the only way to introduce new methods in the surgical management of certain diseases, and new instruments for diagnosis in Germany, was for some one to travel and illustrate their use, as, for instance, the discoverer of the laryngoscope did. The classes here are well attended, and many of the students are American. Drs.

Vissman and John Howard, of Louisville, are in Berlin.

Leaving Berlin, and spending two days in Dresden, I landed here in Vienna, the place of all places in which to study diseases of the eye, ear, throat, and nose. Why this is so depends upon several factors. First, the teachers are excellent; the clinical material is immense in quantity, great variety, and superb in quality; the patients are congregated into contiguous places, covering a comparatively small area, so a man does not waste any time going from place to place. It is possible to put in from eight to ten hours work here each day, each hour being spent at a different clinic.

I met in Vienna Profs. Gruber, Politzer, Stoerk, Schnitzler, Schroetter, and Mauthnes. Profs. Gruber and Politzer "never speak as they pass by." Prof. Gruber's clinic is held daily from 11 to 12 A. M., and Prof. Politzer's in the adjoining room, with a communicating door, from 12 to 1 P. M. They both have the same assistant. They examine fifteen or twenty of their most instructive cases, arrange them in a row, number them, with the diagnosis of each with his or her corresponding number opposite on a blackboard, and set the student to work. Their work is no more thorough than that done in clinics and demonstrating classes at the University of Louisville. I saw in Prof. Gruber's clinic a case of leprosy, involving the hands and feet and the face, the nose having sloughed off, and both eyes having been lost. There were large sloughs on each auricle, and very great thickening of the lining of the external auditory canals. Prof. Politzer, during his lecture, favored me with much English, which he speaks very well indeed. He was exceedingly kind to me in many ways.

The fearlessness with which the eustachian catheter and bougie are used in this country astonishes me. Many in America seem to have given up the bougie (eustachian) entirely. In late years it has been my practice to use it frequently, and on my return home I shall be much more fearless in its use. It has always given favorable re-

sults in my hands. I think of course, that some caution in its use is necessary. If bleeding follows it is best to not force air through the catheter until the following day. The bougies are now made of *blonde* celluloid, this color enabling one to see better any blood on its point.

The nose and throat clinics in Vienna are especially fine. It is wonderful to see the control they have of their patients in these clinics. And there is another factor in making Vienna so favorable as a medical center. The clinicians do with their patients as they choose. Forty or fifty students can use the laryngoscope on any patient their teacher may think necessary. It may be pretty hard on the patient, but it is very good for the student. Prof. Schroetter had several patients brought from their beds for me to examine. There appears to be no limit to the amount of clinical material. There is danger that this richness of resource may prove a drawback to the student, as he is thereby tempted to undertake to see too many cases in the hour. Here the student has the opportunity of treating many cases. This privilege is also accorded him in Berlin.

There is a great opportunity in Vienna for seeing growths of the larynx. Here one can see in a day more of such neoplasm than the throat specialist in our part of the country would encounter in a life-time.

In Prof. Schnitzler's clinic his most able assistants do most of the work. Prof. Stoerk's clinic is quite instructive. He is one of the best inter-laryngeal operators I have seen, very quick and sure.

Prof. Mauthnes is not a very firm believer in antiseptics. He uses hot water and absolute alcohol, but takes no such care of his instruments and dressings as does Hirschberg, of Berlin, to whom he frequently refers.

I saw Prof. Mauthnes inject a drop of tincture of iodine into the vitreous chamber or rather external to the retina, between the latter and the choroid, in a case of detached retina. I had no time to hear the result, as he operated on the day I left Vienna. The operation is not original with him.

If in my further travels I should encounter any thing new in the medical line, I shall be pleased to lay it before the readers of the American Practitioner and News.

VIENNA, AUSTRIA, July 8, 1889. W. CHEATHAM.

## Abstracts and Selections.

THE TREATMENT OF GASTRIC INDIGESTION.—It would be difficult to find any subject in medicine which is more hackneyed than the one on which I now write; but it has seemed to me that some comparatively recent investigations into the physiology of digestion bear so closely upon this important subject, and are so generally ignored by the practitioner, that what I have to say may not seem trite.

Very commonly, in the treatment of gastric dyspepsia proper, pepsin is given in such absurdly small doses as to be almost useless; and yet the prescription as it is taken is intended to aid the true gastric juice, which is not thought strong enough to be capable of performing its functions aright. This is not by any means the result attained in the majority of cases for the following reasons—indeed, the direct digestive action of the dose administered probably brings about the smallest part of the good achieved.

It is a mistaken idea to believe that pepsin and hydrochloric acid are simultaneously secreted and utterly independent bodies, or, in other words, that the pepsin may be formed even if the glands fail to form the acid. We know, from the experiments of Heidenhein and of Langley, as well as many others, that pepsin as such is not secreted by the glands ready formed, but that these tubules secrete a so-called "mother substance" called pepsinogen, which is *absolutely impotent* until it is changed into pepsin by the presence of hydrochloric acid or sodium chloride. Consequently we learn that the two digestive elements are very closely associated, and that *no acid means no pepsin*. In normal life this acid is derived by the splitting up of the chlorides in the blood supplying the glands by the lactic acid, which is present almost constantly in the stomach, owing to decomposition of carbo-hydrates. This assertion, made by Maly, is also confirmed to some extent by Jul. Thomsen, who has shown that very weak acids may displace stronger ones from their bases, and even appropriate the greater part of the base. This is doubtless the reason why common salt is so useful a condiment, since it is broken up in the stomach, thus setting free hydrochloric acid, besides keeping up the alkalinity of the juices of the body which is so necessary to health and the future secre-

tion of gastric juice. It also explains, in a very ingenious manner, the well-known fact that salt added to a glass of milk increases its digestibility to a great degree. Further than this the usefulness of salt in small amount, taken before meals, does not depend, as has been thought, upon an endeavor on the part of the stomach to neutralize the alkali present in a normally acid medium, whereby an excess of gastric juice is secreted, but upon the reason given above. We find, therefore, that, in cases where there is reason to believe that gastric digestion is imperfect, common salt should be used in increased amount in the food so that the quantity of hydrochloric acid may be increased. If, however, there is reason to believe that lactic acid is present in too small a quantity to split up this salt, then hydrochloric acid must itself be used, and where it is employed given freely, in order not only to act thoroughly itself, but also to perform an equally important function, namely, the conversion of pepsinogen into the active body pepsin. In other words, deficiency of pepsin in the juice is to be corrected not by a prescription containing much pepsin and little acid, but rather the reverse, for the pepsin in the prescription is after all an extraneous product, while the pepsin brought into being by the acid is a normal secretion. Of course the quantity of pepsin must depend on a normal formation of pepsinogen; but it should not be forgotten, on the other hand, that as pepsin acts by catalysis, and is a most powerful ferment, only very small quantities of it are absolutely necessary, while large amounts of hydrochloric acid, comparatively speaking, are essential.

In an article recently published in the *Revue Médicale de la Suisse Romande*, Bourget has enunciated some thoughts which are so completely in accord with the views here expressed as to be worthy of quotation. He believes, as does the writer, that the hydrochloric acid is generally the secretion which is lacking in amount, and recommends its free employment as the most important part of the treatment of gastric indigestion. He does not seem to do this because he believes it to increase the pepsin, but only because he thinks the acid secretion is more apt to be deranged than is that of the ferment. According to my own practical experience and the much more reliable information gained by experimental research, it is to be concluded, therefore, that pepsin is to occupy the least prominent position in a prescription for gastric disturbance, and that the acid is to be freely used. Indeed, I am so surely convinced of the importance of the acid in its double sphere that I fear I am sometimes inclined to give almost no pepsin at all.—*Dr. H. A. Hare, University Magazine.*

**THE TREATMENT OF THE ACUTE STAGE OF ECZEMA.**—D. Mackintosh, M. D., C. M., London, writing in *The Practitioner*, says in the treatment of the acute stage of eczema two essentials must be reckoned with before we proceed to tackle the disease itself. The first of these is, that the patient must not wash the eczematous parts, and this advice he must religiously observe. "Wash not at all," is the first commandment in eczema. The patient must neither wash with, nor yet without, soap, nor with the usual adjuncts of bran steeped in hot water, oatmeal, milk and water, butter-milk, whey, sour milk, or rain-water, or any other washes; all of these seriously delay and hamper treatment. Persistent washing predisposes to eczema by drying the skin, and depriving it of the unctuous secretions which impart to it suppleness and softness. For the same reason frequent washing with soap and water is disastrous to the growth of hair, it changes its natural color to a lighter hue, the natural gloss is lost, the hair becomes dry, prematurely gray, and early baldness is favored. This process of destruction is materially hastened by washing the head with warm or hot water and soap during cold weather. The head and beard should be dressed and kept clean by combing and brushing, a process all-sufficient for purposes of cleanliness, and the rational method for preserving a fine head of hair.

In eczema of the head and face the more essential parts to wash, such as the corners of the eyes and angles of the mouth, may be touched lightly with a small piece of soft sponge, made damp with cold water, and immediately dabbed dry. Warm and hot water should be discarded in the neighborhood of the eczematous skin. A patient suffering from eczema of the head and face only may, of course, sponge and wash his body with warm water as frequently as necessary. Coffee, strong tea, and alcoholic drinks should be forbidden.

The second essential is that the bowels be kept well open. In the case of children, gray powder, rhubarb, and bicarbonate of sodium, a grain of each, taken as required every second or third night, will answer every purpose; or gray powder and magnesia will do equally well. In adults saline medicines hold the first rank. The following is a useful combination:

Magnesii sulphatis.....5vj;

Sodii bicarbonatis.....5i;

Infusum gentianæ co. ad.....3vj.

S. Take a sixth part three times a day before meals.

Sulphate of magnesium is far and away the

best of all purgative medicines in eczema—the best because the mildest, and certainly one of the most effectual; but it must be taken at the proper time and in the proper quantity. The proper time is an hour before meals—preferably in the morning before breakfast, although it may be taken before any other meal with nearly equal benefit. The proper quantity is three drams, dissolved in three parts of a tumblerful of cold water or soda water. Hot water does not materially help its action, and it makes the drug more nauseous. Three drams of sulphate of magnesium dissolved in an ounce of chloroform-water, followed by a cup of tea or head tea, can be swallowed almost without taste or inconvenience. A four- or five-grain blue pill taken at night, and the same draught next morning, has its advantages; or, where free purgation is desired, the following pill at bedtime, and the draught in the morning:

Ext. colocynth. co.....gr. iij;

Pil. hydrarg.....gr. j;

Ext. hyoseyam.....gr. j.

Ft. pil.

Where there is torpidity of the liver, a combination of cascara with nux vomica is equal, if not superior, to any other:

Ext. cascara. sagrad. liq.....3iijss;

Tinct. nuc. vomica.....5i;

Glycerin.....5iij;

Infus. gent. co. ad.....5viij.

Take one ounce morning and evening, if required.

Arsenic and iodide of potassium internally I have found of very little use. Of course gouty eczema must be suitably treated.

The great desideratum is the appropriate external treatment. The following ointment in most cases pretty nearly approaches the character of a specific:

Bismuth. subnit.....3iv;

Zinc. oxid.....3j;

Acid. carbol.....5ss;

Vaselin. alb. ....5ij.

Ft. ung.

Sometimes I use this form:

Bismuth. subnit.....3ij;

Zinc. oxid.....5ss;

Glycerin.....3jss;

Acid. carbol.....℥xx;

Vaselin. alb. ....5vj.

Ft. ung.

The latter ointment acts as a balm to the irritable skin.

When constant tingling and irritation disturb the patient's rest at night, this lotion is valuable:

Bismuth. subnit .....3j;  
 Glycerin.....3iv;  
 Acid. carbol.....℥xij;  
 Aquam rosæ ad.....3i.

S. Shake up and apply with a camel's hair pencil.

During the day, when business has to be attended to, and the ointment can not be applied, a powder will be found useful:

Cimolite ..... }  
 Bismuth. subnit..... } āā part. æqual.  
 Zinc. oxid..... }

F. pulv.

In more chronic cases the famous *unguentum metallorum* still holds its own. It consists of

Unguent. zinc..... }  
 “ plumb. acet.... } āā part. æqual.  
 “ hydrarg. nitrat. }

M.

This ointment I occasionally vary by substituting white precipitate for the nitrate of mercury ointment.

THE EFFECTS PRODUCED ON MAN BY SUBCUTANEOUS INJECTIONS OF A LIQUID OBTAINED FROM THE TESTICLES OF ANIMALS.—On the 1st of June last I made at the Société de Biologie of Paris a communication on the above subject, which was published in the *Comptes Rendus* of that Society on June 21st (No. 24). I will give here a summary of the facts and views contained in that paper and in two subsequent ones, adding to them some new points.

There is no need of describing at length the great effects produced on the organization of man by castration, when it is made before the adult age. It is particularly well known that eunuchs are characterized by their general debility and their lack of intellectual and physical activity. There is no medical man who does not know also how much the mind and body of men (especially before the spermatogenic glands have acquired their full power, or when that power is declining in consequence of advanced age) are affected by sexual abuse or by masturbation. Besides, it is well known that seminal losses, arising from any cause, produce a mental and physical debility which is in proportion to their frequency. These facts, and many others, have led to the generally-admitted view that in the seminal fluid, as secreted by the testicles, a substance or several substances exist which, entering the blood by resorption, have a most essential use in giving strength to the nervous system and to other parts. But if what may be called spermatogenic anemia leads to that conclusion, the opposite state, which can be named spermatogenic plethoria, gives as strong a testimony in favor of that conclusion. It is

known that well-organized men, especially from twenty to thirty-five years of age, who remain absolutely free from sexual intercourse or any other causes of expenditure of seminal fluid, are in a state of excitement, giving them a great, although abnormal, physical and mental activity. These two series of facts contribute to show what great dynamogenic power is possessed by some substance or substances which our blood owes to the testicles.

For a great many years I have believed that the weakness of old men depended on two causes—a natural series of organic changes and the gradually diminishing action of the spermatogenic glands. In 1869, in a course of lectures at the Paris Faculty of Medicine, discussing the influence possessed by several glands upon the nervous centers, I put forward the idea that if it were possible without danger to inject semen into the blood of old men, we should probably obtain manifestations of increased activity as regards the mental and the various physical powers. Led by this view, I made various experiments on animals at Nahant, near Boston (United States), in 1875. In some of those experiments, made on a dozen male dogs, I tried vainly, except in one case, to engraft certain parts or the whole body of young guinea-pigs. The success obtained in the exceptional case served to give me great hopes that by a less difficult process I should some day reach my aim. This I have now done. At the end of last year I made on two old male rabbits experiments which were repeated since on several others, with results leaving no doubt as regards both the innocuity<sup>1</sup> of the process used and the good effects produced in all those animals. This having been ascertained, I resolved to make experiments on myself, which I thought would be far more decisive on man than on animals. The event has proved the correctness of that idea.

Leaving aside and for future researches the questions relating to the substance or substances which, being formed by the testicles, give power to the nervous centers and various other parts, I have made use, in subcutaneous injections, of a liquid containing a very small quantity of water mixed with the three following parts: First, blood of the testicular veins;<sup>2</sup> secondly, semen; and thirdly,

<sup>1</sup> This innocuity was also proved on a very old dog by twenty subcutaneous injections of a fluid similar to that I intended to employ on myself. No apparent harm resulted from these trials, which were made by my assistant, Dr. D'Arsonval.

<sup>2</sup> For reasons I have given in many lectures in 1869 and since, I consider the spermatogenic as also the principal glands (kidneys, liver, etc.) as endowed, besides their secretory power, with an influence over the composition of blood, such as is possessed by the spleen, the thyroid, etc. Led by that view I have already made some trials with the blood returning from the testicles. But what I have seen is not sufficiently decisive to be mentioned here.

juice extracted from a testicle, crushed immediately after it has been taken from a dog or a guinea-pig. Wishing in all the injections made on myself to obtain the maximum of effects, I have employed as little water as I could. To the three kinds of substances I have just named I added distilled water in a quantity which never exceeded three or four times their volume. The crushing was always done after the addition of water. When filtered through a paper filter the liquid was of a reddish hue, and rather opaque, while it was almost perfectly clear and transparent when Pasteur's filter was employed. For each injection I have used nearly one cubic centimeter of the filtered liquid. The animals employed were a strong, and according to all appearances, perfectly healthy dog (from two to three years old), and a number of very young or adult guinea-pigs. The experiments, so far, do not allow of a positive conclusion as regards the relative power of the liquid obtained from a dog and that drawn from guinea-pigs. All I can assert is that the two kinds of animals have given a liquid endowed with very great power. I have hitherto made ten subcutaneous injections of such a liquid—two in my left arm, all the others in my lower limbs—from May 15th to June 4th last. The first five injections were made on three succeeding days with a liquid obtained from a dog. In all the subsequent injections, made on May 24th, 29th, and 30th, and June 4th, the liquid used came from guinea-pigs. When I employed liquids having passed through Pasteur's filter, the pains and other bad effects were somewhat less than when a paper filter was used.

Coming now to the favorable effects of these injections, I beg to be excused for speaking so much as I shall do of my own person. I hope it will easily be understood, that if my demonstration has any value—I will even say any significance—it is owing to the details concerning the state of my health, strength, and habits previously to my experiments, and to the effects they have produced.

I am seventy-two years old. My general strength, which has been considerable, has notably and gradually diminished during the last ten or twelve years. Before May 15th last I was so weak that I was always compelled to sit down after an hour's work in the laboratory. Even when I remained seated all the time, or almost all the time, in the laboratory, I used to come out of it quite exhausted after three or four hours' experimental labor, and sometimes after only two hours. For many years, on returning home in a carriage by six o'clock, after several hours passed in the laboratory, I was so extremely tired that I invariably had to go to bed after having hastily taken

a very small amount of food. Very frequently the exhaustion was so great, that although extremely sleepy, I could not for hours go to sleep, and I only slept very little, waking up exceedingly tired.<sup>3</sup>

The day after the first subcutaneous injection and still more after the two succeeding ones a radical change took place in me, and I had ample reason to say and to write that I had regained at least all the strength I possessed a good many years ago. Considerable laboratory work hardly tired me. To the great astonishment of my two principal assistants, Drs. D'Arsonval and Hénoque, and other persons, I was able to make experiments for several hours while standing up, feeling no need whatever to sit down. Still more: one day (the 23d of May), after three hours and a quarter of hard experimental labor in the standing attitude, I went home so little tired that after dinner I was able to go to work and to write for an hour and a half a part of a paper on a difficult subject. For more than twenty years I had never been able to do as much.<sup>4</sup> From a natural impetuosity, and also to avoid losing time, I had, till I was sixty years old, the habit of ascending and descending stairs so rapidly that my movements were rather those of running than of walking. This had gradually changed, and I had come to move slowly up and down stairs, having to hold the banister in difficult staircases. After the second injection I found that I had fully regained my old powers, and returned to my previous habits in that respect.

My limbs, tested with a dynamometer, for a week before my trial and during the month following the first injection, showed a decided gain of strength. The average number of kilograms moved by the flexors of the right forearm, before the first injection, was about 34 (from 32 to 37), and after that injection 41 (from 39 to 44), the gain being from 6 to 7 kilograms. In that respect the fore arm flexors reacquired, in a great measure, the strength they had when I was living in London (more than twenty-six years ago). The average number of kilograms moved by those muscles in London in 1853<sup>5</sup> was 43 (40 to 46 kilograms).

<sup>3</sup> I ought to say, that notwithstanding this fact, my general health is and has been almost always good, and that I had very little to complain of, excepting muscular and muscular rheumatism.

<sup>4</sup> My friends knew, that owing to my excessive labors and certain habits, I have for many years been troubled very early and for a long while with nervousness, beginning it generally between four and half-past five, a great many years I had lost all my strength and nervous mental work after dinner. Since my first injection, I have very rarely experienced nervousness, and for two, three, and once or twice for four days.

<sup>5</sup> I have a record of the strength of my fore arm, taken in March, 1860, when I first came to America. At that time I was fifty kilograms. I have the last time the dynamometer moved was thirty-eight kilograms. With me, and probably to the first injection, the strength of my fore arm was regained. Since the injection it has been forty-four.

I have measured comparatively, before and after the first injection, the jet of urine in similar circumstances—that is, after a meal in which I had taken food and drink of the same kind in similar quantity. The average length of the jet during the ten days that preceded the first injection was inferior by at least one quarter of what it came to be during the twenty following days. It is therefore quite evident that the power of the spinal cord over the bladder was considerably increased.

One of the most troublesome miseries of advanced life consists in the diminution of the power of defecation. To avoid repeating the details I have elsewhere given in that respect, I will simply say that after the first days of my experiments I have had a greater improvement with regard to the expulsion of fecal matters than in any other function. In fact a radical change took place, and even on days of great constipation the power I long ago possessed had returned.

With regard to the facility of intellectual labor, which had diminished within the last few years, a return to my previous ordinary condition became quite manifest during and after the first two or three days of my experiments.

It is evident from these facts and from some others that all the functions depending on the power of action of the nervous centers, and especially of the spinal cord, were notably and rapidly improved by the injections I have used. The last of these injections was made on June 4th, about five weeks and a half ago. I ceased making use of them for the purpose of ascertaining how long their good effects would last. For four weeks no marked change occurred, but gradually, although rapidly, from the 3d of this month (July) I have witnessed almost a complete return of the state of weakness which existed before the first injection. This loss of strength is an excellent counterproof as regards the demonstration of the influence exerted on me by the subcutaneous injections of a spermatic fluid.

My first communication to the Paris Biological Society was made with the wish that other medical men advanced in life would make on themselves experiments similar to mine, so as to ascertain, as I then stated, if the effects I had observed depended or not on any special idiosyncrasy or on a kind of auto-suggestion without hypnotization, due to the conviction which I had before experimenting that I should surely obtain a great part at least of these effects. This last supposition found some ground in many of the facts contained in the valuable and learned work of Dr. Hack Tuke on the "Influence

of the Mind over the Body." Ready as I was to make on my own person experiments which, if they were not dangerous, were at least exceedingly painful, I refused absolutely to yield to the wishes of many people anxious to obtain the effects I had observed on myself. But, without asking my advice, Dr. Variot, a physician who believed that the subcutaneous injections of considerably diluted spermatic fluid<sup>6</sup> could do no harm, has made a trial of that method on three old men—one fifty-four, another fifty-six, and the third sixty-eight years old.<sup>7</sup> On each of them the effects have been found to be very nearly the same as those I have obtained on myself. Dr. Variot made use of the testicles of rabbits and guinea-pigs.

These facts clearly show that it was not to a peculiar idiosyncrasy of mine that the effects I have pointed out were due. As regards the explanation of those effects by an auto-suggestion, it is hardly possible to accept it in the case of the patients treated by Dr. Variot. They had no idea of what was being done; they knew nothing of my experiments, and were only told that they were receiving *fortifying* injections. To find out if this qualification had any thing to do with the effects produced, Dr. Variot, since the publication of his paper, has employed similar words of encouragement, while making subcutaneous injections of pure water on two other patients, who obtained thereby no strengthening effect whatever.<sup>8</sup>

I believe that, after the results of Dr. Variot's trials, it is hardly possible to explain the effects I have observed on myself otherwise than by admitting that the liquid injected possesses the power of increasing the strength of many parts of the human organism. I need hardly say that those effects can not have been due to structural changes, and that they resulted only from nutritive modifications, perhaps in a very great measure from purely dynamical influences exerted by some of the principles contained in the injected fluid.

I have at present no fact to mention which might serve to solve the question whether it would be possible or not to change structur-

<sup>6</sup>In my third communication to the Biological Society, I said that both the intense pain each injection has caused me and the inflammation it has produced would be notably diminished if the liquid employed were more diluted. The three cases of Dr. Variot have proved the exactitude of my statement. He made use of a much larger amount of water, and his patients had to suffer no very great pain and no inflammation.

<sup>7</sup>The paper of Dr. Variot and my remarks upon it have appeared in the "Comptes Rendus de la Société de Biologie," No. 26, 5 Juillet, 1889, pp. 451 and 454.

<sup>8</sup>Since writing the above I have received a letter from Dr. Variot announcing that, after injecting the liquid drawn from the testicles into these two individuals, he has obtained the same strengthening effects I have myself experienced.

ally muscles, nerves, and the nervous centers by making during a good many months frequent injections of the fluid I have used. As I stated at the Paris Biological Society, I have always feared, and I still fear, that the special nutritive actions which bring on certain changes in man and animals, from the primitive embryonal state till death by old age, are absolutely fatal and irreversible. But in the same way that we see muscles which have from disease undergone considerable structural alterations regain some times their normal organization, we may, I believe, see also some structural changes not essentially allied with old age, although accompanying it, disappear to such a degree as to allow tissues to recover the power they possessed at a much less advanced age.

Whatever may be thought of these speculations, the results I have obtained by experiments on myself and those which have been observed by Dr. Variot on three old men show that this important subject should be further investigated experimentally.<sup>2</sup>—*Dr. Brown Sequard, London Lancet.*

**STROPHANTHUS AS A LOCAL ANESTHETIC.**—Many of the drugs which are useful in the treatment of cardiac disease also possess a local anesthetic action. There is, of course, no connection, as far as can be seen at present, between the two actions. The local anesthetic action of erythrophleine was investigated last year by many observers; the conclusions arrived at were that, although it possessed a powerful local anesthetic action, it causes irritation and dilatation of the conjunctiva, and in some cases even severe inflammation. It was thus much inferior to cocaine, whose action is accompanied by a constriction of vessels and consequent pallor of the part. Helleborin, the glucoside from the Christmas rose, is also a local anesthetic and cardiac tonic; one fortieth of a grain in solution placed on a conjunctiva of rabbit causes complete anesthesia in fifteen minutes, and there is at the same time no interference with the movements of the pupil and no dilatation of vessels. The action of this glucoside is therefore like that of the alkaloid cocaine; but it has not yet come into general use. Steinach has lately shown that strophanthus seeds contain a body not identical with strophanthin, which when placed on the conjunctiva produces in twenty-five to thirty minutes complete anesthesia, lasting from two to twelve hours. There are no great signs of irritation,

but if applied to the eye of man it causes a slight feeling of burning, with a passing hyperemia of the conjunctiva. This condition may pass on to cloudiness of the cornea in animals. The local anesthetic action of strophanthus is, therefore, chiefly of pharmacological interest, like that of erythrophleine. Cocaine still holds its own when judiciously employed.—*British Medical Review.*

**PEPTONES AND NUTRITION.**—A great deal of attention has of late years been paid to the chemical changes occurring in the stomach and intestine, both in health and in disease. It can not be said that our knowledge on these points is at all complete. In artificial digestion it is well known that the action of pepsin in the presence of free hydrochloric acid consists in the transformation of soluble albuminoids into peptones or intermediate products, such as acid albumin and albumoses, being at the same time produced. The end product of gastric digestion, namely, the peptone, has been almost universally considered as the form in which the proteids are absorbed and with this idea peptones are administered to patients whose digestion is deficient. The idea, however, that proteids are absorbed as peptones to any great extent has been strongly combated by Brücke even as late as 1885; and if Brücke's idea is correct, there really does not seem much rationale for administering peptones to invalids. There is, however, much more evidence for them against the idea of the nutritive value of peptones. Thus, Plósz showed that in dogs peptones could be substituted for other proteids in the food, and with beneficial results. In an experiment lasting eighteen days, a dog received altogether 560 grams of peptone (made with pepsin, 422 grams of sugar, and 309 grams of fat); all the functions of the body remained normal, and the animal gained 3.75 per cent in weight. Valt, however, has shown that although peptones can maintain the nitrogen-equilibrium, they have not the nutritive value of the ordinary proteids taken in as food; after seven months, rats fed with peptones instead of ordinary proteids, die. The question is evidently a very important one to determine. If the peptones formed in the stomach are not nutritive to the animal, they must be considered as decomposition products of the proteids taken in as food; if, however, they are nutritive, they would be considered as hydrated products, the proteids taken in as food undergoing this change in order, by increasing the solubility of the substance, to in-

<sup>2</sup>It may be well to add that there are good reasons to think that subcutaneous injections of a fluid obtained by crushing ovaries just extracted from young or adult animals, and mixed with a certain amount of water, would act on old women in a manner analogous to that of the solution extracted from the testicles injected into old men.

crease its absorbability. Indeed, Hofmeister and Henninger, by dehydrating peptones, have been able to obtain a proteid resembling the proteids taken in as food, being coagulated by heat.

There is, therefore, more accurate evidence in favor of peptones having a great nutritive value than against; that they are, in fact, the modifications in which proteid food is absorbed in the stomach and intestine. This being so, what becomes of the peptone? None, or perhaps only a trace, is found in the lymphatics of the mesentery, only a trace is found in the portal blood, and in the blood of the general system it is extremely doubtful whether any is present. Hofmeister asserts that a trace is found in arterial blood, while none is present in venous blood. At any rate, there is a concurrence of opinion that peptones are not present in the blood and lymphatic vessels of the body in sufficient quantity to account for the proteid taken in as food, supposing the peptones are absorbed as such. An interesting experiment of Hofmeister's points to the fact that in traversing the wall of the living intestine, peptones undergo an important change. In the first place, during digestion, peptones are found in quantity in the mucous membrane itself, but are not found deeper down in the intestinal wall. Secondly, an animal was killed in full digestion, and two pieces of intestine removed; one piece was heated to destroy the living tissues, while the other piece was kept for a short time at the temperature of the body. The first piece of intestine contained peptone in abundance in its walls, while the second piece contained none. This piece of intestine still lived, and was able to transform the peptone it contained, while the first piece, being killed, was unable to do this.

Here, then, is a case of "vital" absorption; the peptones do not simply diffuse through the wall of the intestine, but are taken up by the mucous membrane and transformed by it. Transformed, but into what? This is the next question to decide. Presumably it is transformed into serum albumin, as this is the chief proteid found in the liquid part of the blood. To the elucidation of this question experiments have been undertaken in Professor Kronecker's laboratory in Berne, by two ladies, Fräulein Nadine Popoff, and Fräulein Julia Brinck. The results are published in the *Zeitschrift für Biologie*. The fact which was the basis of these experiments was first discovered by Von Ott, namely, that peptone, when placed in the stomach of a living dog, was

transformed into serum albumin before it entered the walls of the digestive tract. There are obviously many difficulties at arriving at a correct conclusion on this point. Large quantities of peptone which would facilitate chemical analysis can not be used, as the conditions would not be natural. At no time during natural digestion is there a large quantity of peptone in the stomach. With small quantities of peptone it is difficult by chemical analysis to be certain of the form of proteid present. Then, even if part of the peptone were changed into serum albumin, it would be difficult of detection by chemical means, although not impossible. Fräulein Popoff and Brinck have not applied this chemical test, but have employed a physiological one. The frog's heart, as is well known, may be separated from the animal and be kept pulsating for many hours if a proper nutrient liquid be supplied to it. One of the best nutrient fluids is 0.6 per cent salt solution, to which a certain proportion of serum is added; this liquid will keep the heart beating for many hours. If, however, only salt solution be used, the heart comes to a standstill after a short time; and if peptones be added to the salt solution, the heart may be stimulated to beat for a short period, but soon becomes quiescent.

Now the chief fact brought out by Fräulein Popoff's experiments is that if a solution of peptone be placed in the stomach of a living dog and removed after fifteen minutes, it is found capable of sustaining the activity of the frog's heart, while previous to being placed in the stomach it was incapable of doing this. This change in the peptone solution is more marked if it be placed in the small intestine instead of the stomach. A curious fact brought out by the research is that while the peptone formed by pepsin can be changed in the manner described by the stomach and intestine, that formed by the pancreas is unaltered; in other words, pancreas peptone, both before and after the exposure to the action of the intestinal wall, does not act as a nutrient fluid for the heart.

Fräulein Brinck has repeated and confirmed Fräulein Popoff's experiments, and has extended them. She has shown, for example, that the effect on the peptone is not simply due to temperature, for a solution kept in the incubator at the temperature of the stomach does not sustain the cardiac beat. Moreover, the stomach and intestine seem to retain their regenerating power for a short time after the circulation of the blood has been stopped: a fact previously

discovered by Hofmeister. The regenerating effect is, therefore, ascribed to the epithelial cells lining the stomach and intestine, and so it was naturally suggested that other epithelial cells might have the same power. It was found, indeed, that the frog's heart could change the peptone solution, rendering it nutritive to itself. Thus, if the solution be passed four to ten times through the heart, it then becomes capable of sustaining the cardiac activity. Another interesting aspect of the subject was shown by the fact that a pepsin-peptone solution, which had just begun to decompose, was a powerful sustainer of the heart's action; while if the decomposition be allowed to progress, the liquid becomes a cardiac poison, instead of a cardiac food. Fränklein Bruck suggests that the first effect is due to the special organism she describes, *micrococcus restitutus*, forming serum albumin from the peptone; while in the later stages of the action of another organism growing in the liquid a poison is developed. The first effect would, therefore, be another instance of the formation by a cell of serum albumin out of albumose and peptone. Here the matter at present rests. Although the researches discussed are extremely interesting, until the body formed from peptone in the stomach and intestine is separated and chemically tested, it seems premature to call it "serum albumin." Moreover, if peptones are the end-products of proteolytic digestion, being formed to aid the absorption of proteid food, it is difficult to see the rationale of their transformation into serum albumin within the cavity of the stomach and intestine; one would rather expect the change to occur in the walls. No doubt future researches will elucidate these points.—*British Medical Journal*.

**MILIARY PYURIA.**—The two cases of pyuria recently reported by Dr. H. Handford, have brought in review a subject much neglected in text books. I have in mind a case of pyuria in which miliary bodies were found similar to those mentioned by Dr. Handford, and this was diagnosed as a case of tubercular kidney involving the pelvis. It is a very easy matter to regard these as simple and accidental globules of pus, non opus, flat cells, and blood corpuscles agglutinated in their transit down the ureter or ureters, and subsequently rolling into the bladder, but what we need is a discourse in the Journal by a competent observer of long experience, treating of tubercular disease of the bladder in its relation to urinary deposits.

Doubtless most practitioners believe that tubercular cell structure is broken down into pus and granular *dibris* at the kidney before entering the bladder, but it appears rational to believe that in tubercular pelvis or ureter we may have a shedding of the epithelial layer, exposing the granules of tubercular disease, which start in the submucous layer, and these tubercular deposits when exposed and about to degenerate, may be washed down into the bladder, and show under the microscope the greater part of their primary structure.

It should be remembered that primary tubercular disease of the kidney may be far advanced without showing pus in the urine, and but little albumen.—*Benjamin Walker, M.D., British Medical Journal*.

**PILOCARPINE IN DEAFNESS.**—I. J. C., an old man suffering from locomotor ataxy, whose ear history is this: A year or two ago he could hear a clock ticking in his room, but has gradually lost this little amount of hearing. One has to shout to make him hear at all. Drumming noises in both ears. No discharge at any time. Watch not heard in contact with either ear. Tuning-fork heard on vertex, mastoids, and teeth, but not close to concha, but bone conduction markedly deficient. Right eustachian tube blocked; left pervious. Some wax was found in the right meatus, which was syringed out and pilocarpine treatment commenced (gr.  $\frac{1}{15}$  once a day) on March 26th. The injection was gradually increased to gr.  $\frac{1}{4}$ . This caused profuse sweating, and, after a time, salivation. Result no good whatever, although the treatment was continued seventeen days.

II. Miss A. M. W., aged sixty-five. Deaf thirty years, coming on gradually after a shock. Bone conduction impaired. Both eustachian tubes free. Infection began March 20th and continued until April 27th. Profuse salivation and sweating, but no good was effected.

III. Mrs. M. P., aged sixty, can hear conversation if she is spoken to close by. Uses a speaking tube. Had inflammation of left tympanic cavity in 1887, followed by perforation. Tinnitus, giddiness. Watch not heard in contact with either ear. Tuning-fork faintly heard on vertex and back mastoids. The eustachian tube of the worse ear, the right, was previously the left was apparently obstructed. Profuse salivation and sweating was produced. Treatment continued a month. The general result was not encouraging. For a time she thought she

heard better, but the effect, if any, soon passed off, and she heard no better at the end. The tinnitus was as bad as ever.

IV. Mrs. A. W., aged sixty-eight. Chronic rheumatic arthritis. This patient's hearing varies. Bone conduction a minus quantity. Before she began the treatment she could hear the ticking of a clock in the room. Pilocarpine injections were continued about three weeks. During the treatment she thought there was great improvement. She could hear the church bells and the rooks outside her window, but the improvement was very transient, and at the end she could not hear the clock which she formerly heard.

V. Miss J. L., aged forty-four. Can hear only by shouting into the left ear. Has been deaf nine years. Deafness appears to be a family complaint. Watch not heard in contact with either ear. Tuning-fork not heard on vertex, mastoids, nor teeth. Tinnitus both ears, especially in the right; giddiness occasionally. Cerumen in both ears, which was removed by the syringe, and the treatment commenced and continued three weeks. The result was very extraordinary, and was recorded by her in a humorous way. She said her nurse had become very noisy, and she knew all the secrets of the fire-place, when the poker dropped, and even when a coal fell out of the fire. She appeared to hear sounds better, but not conversation, except once or twice, when she heard what her nurse and attendant said. Once or twice, too, to her great satisfaction and joy, she heard the tuning-fork, not only on her mastoid but even a short distance from the concha. The improvement, however, was not maintained, and she became as deaf as ever.

This was the only case which can fairly be said to have given a glimmer of hope; but it was very transient, and no real good was effected.—*Dr. Woodhouse, British Medical Journal.*

A CASE OF CARBUNCLE TREATED BY CARBOLIZED SPRAY.—Mr. H., aged sixty-five years, was visited by me on June 15th for a tense, red, hot, and painful swelling, mainly situated over the right scapula, but extending upward toward the neck, downward toward the lower ribs, outward toward the shoulder and chest side, and inward limited at the middle line. At three points—one at the superior angle and two at the interior angle—there was distinct fluctuation.

Having recently read Professor Verneuil's report to the Academy of Medicine of Paris on the above treatment, I tried it, with the

following result: I used a spray of 1 to 12 carbolic acid and distilled water, followed by the application of a linen square, eight inches by eight, steeped in carbolized oil 1 in 20, over which a linseed poultice was laid.

June 16th. Temperature, 99.7° F.; pulse, 90. Ordered potassium bromide gr. xv and chloral hydrate mixture gr. xv, with tincture of tolu Mx in water 3 j at bedtime for sleeplessness.

June 17th. Temperature, 99.2°; pulse, 84. The upper point over superior angle of scapula was discharging a sweet, healthy pus through about a dozen perforations like pinholes.

June 18th. Temperature, 98.8°; pulse, 84. Discharge very profuse.

June 21st. Temperature, 98.4°; pulse, 64. Discharge still free; both the lower points had subsided.

June 28th. Temperature normal; pulse, 84; tongue clean. On the 25th slight sanious discharge, after which no further discharge. Back regaining its former suppleness; no swelling; upper wound almost healed. The patient's appetite was voracious, and he looked in every way improved; his skin was soft, his tongue clean, and his spirits good, and sleep undisturbed.—*E. H. Ryan-Tenison, British Medical Journal.*

IODOFORM ERUPTIONS.—The following case may throw some light on the questions raised by Mr. Arthur Cooper in the *Journal* of June 15th.

Mr. C., aged seventy-two, came under my care in April, 1888, suffering from an epitheliomatous ulcer situated behind the lobe of the ear. The pain was intense, and all idea of radical treatment being negated by the patient's age, at a consultation on May 2d, it was decided to apply iodoform, with the idea of allaying the pain. I provided the patient with some iodoform, "the crystalline variety," and on May 5th the pain was much less severe. So it continued until May 18th, when the pain was much worse; and on inquiry I found that the patient had used all the iodoform I had provided him with, and had procured some for himself, which on examination proved to be "the pulverized variety." From the date of using this he noticed the pain increase.

I procured some more of the crystalline variety, with the effect that the pain was speedily allayed; but three days afterward I noticed an erythematous blush spreading over the side of the face and head. There were no signs of iodoform-poisoning, and I regarded it merely as an evidence of local

irritation. Shortly after this the patient passed out of my care, and I saw no more of him.

The case indicates that, as far as regards the effect on pain, the crystalline is superior to the pulverized variety. In this case the drug was continuously applied for three weeks before any sign of an eruption appeared, while its beneficial action was manifest; and in the treatment of painful ulceration of any kind I am inclined to use the crystalline variety in preference to all others.—George C. Peachey, *British Med. Jour.*

**ACROMEGALY.**—Although there may be not much virtue in a name, yet the man who first gives a name, even though it be his own patronymic, to a clinical group of signs and symptoms, confers a real benefit on clinical medicine and pathology. Acromegaly, considered as a word, is cacophonous, but Dr. Pierre Marie did a service to medical science, if not to philology, by its introduction. So long as some unusual complex of symptoms has no name, each case is apt to be regarded by its observer as an isolated case of merely curious interest. As soon as a name is applied, a knowledge of the condition is popularized. A reader who will not be at the trouble to read "a report of a case in which there was hypertrophy of the head, hands, and other parts" may yet have his curiosity aroused by the novel term acromegaly, and he will be prepared to recognize a case of what has now become for him a distinct disease. The name is not yet more than three years old, yet the number of cases since recorded is considerable. In this country we may refer to the two cases reported to the Clinical Society by Mr. Godlee and Messrs. Hadden and Balance respectively last year, and the two cases shown to the Birmingham and Midland Counties Branch of the British Medical Association by Drs. Saundby and Simon. The most recent case recorded abroad is one observed by Dr. Farge, of Angers, and reported by him with illustrations in *Le Progrès Medical* for July 6th. The patient was a man, aged thirty-one, who dated the development of his deformity from a severe accident while tree-felling in his twenty-fourth year. He was confined to his bed for six months, and when he got up he found that his head was increased enormously in size, and that his back was humped. He was admitted into the Hôtel Dieu in Angers for slight bronchitis last February. He then stood five feet one inch, had an enormous head sunk between his high shoulders, and projected forward by the curvature of the spine, which was uniformly kyphotic from the vertebra prominens to the sacrum. His limbs were

short and large. His face suggested that of an animal, but was not without intelligence, and he spoke distinctly in a deep hoarse voice, though the tongue and lips were much enlarged. There was no hypertrophy of the thyroid. He complained most of stiffness and discomfort in the back, and these symptoms were considerably relieved by suspension.—*British Medical Journal.*

**A NEW MODE OF ADMINISTERING COD-LIVER OIL.**—M. Letaki calls attention to a method of administering cod-liver oil which seems to possess considerable advantage (*Journal de Médecine et de Chirurgie*). If equal parts of cod-liver oil and lime-water are mixed together, a milky liquid is obtained which is inodorous, has the consistency of syrup, and may be flavored at will either with lemon syrup or vanilla, or other extract. The cod-liver oil thus saponified is almost agreeable to the taste, does not adhere to the mouth, and does not leave any nauseous after-taste. In addition to these advantages saponified cod-liver oil is preferable to the various emulsions which are on the market. In the first place, it is permanent, the fluid remaining homogeneous. It is readily assimilated even by weak stomachs; it may be administered even during diarrhea; besides, it is combined with calcareous elements, which are likewise indicated in the affections which call for the use of the cod-liver oil. Of course, the saponified oil may be associated with the phosphates or hypophosphites of lime. Finally, it may be readily and rapidly prepared, and is of low price.—*Therapeutic Gazette.*

**OPHTHALMIA NEONATORUM.**—According to the report of the Royal Commission on the Blind, the Deaf and Dumb, etc., one of the most fruitful causes of blindness is the inflammation of the eyes of newly-born infants, and the Ophthalmological Society estimated that 30 per cent of the inmates of asylums and 7000 persons in the United Kingdom had lost their sight from that cause. Various remedies are mentioned by the commissioners, but they all appear to depend chiefly for their success on prompt application. The subject is really one of the highest importance, and has been most carefully worked out for Europe, and for Germany in particular, by Professor Magnus of Breslau. This observer finds that no less than 71.20 per cent of all who become blind during the first year of life are rendered blind by neonatal ophthalmia; and even of those who become blind before the twentieth year of life it constitutes as much as 23.50 per cent. Looking at the subject in another way, he shows

that, of every 10,000 children under five years of age, 4.28 are blinded by purulent ophthalmia. Owing to the ignorance of the serious nature of the disease, or of the possibility of arresting its progress by judicious treatment, in this country the proportion of the blind from blennorrhœa in the Normal College of Music is no less than 32.14 per cent; while in the blind asylums in Switzerland the proportion is 26 per cent; in the blind asylums of Austria, Hungary, and Italy about 20 per cent; while in Spain and Belgium it falls to about 11 or 12 per cent. It has been suggested, in view of these statistics, at the time of the registration or the birth of a child a paper should be given to the parents or relatives on which a short account of the disease should be printed, pointing out its gravity, the best method of treatment by simple means, and the danger of delay. There can be no doubt that such information would materially lessen the percentage of blindness, and that such a system should be adopted, especially as the expense would be extremely small.—*London Lancet*.

**NASAL ORIGIN OF SPASM OF THE GLOTTIS.** Dr. Ruault concludes (*Medical News*): (1) Certain lesions of the mucous membrane of the nasal fossæ may provoke reflex spasm of the glottis, so serious as to demand tracheotomy. (2) These attacks may continue for years, and yield quickly to treatment of the nasal affection on which they have depended. (3) Hysterical females are the most frequent subjects, although both sexes, infants as well as adults, may be affected. (4) Bronchial spasm may coexist, and also affections of the voice. (5) Prognosis is favorable, the case being recognized. (6) The treatment of the attack consists in the application of cocaine, the administration of chloroform, and tracheotomy, if necessary. (7) Treatment of the affection consists in the treatment of the nasal abnormality.

**MICRO-ORGANISMS IN EMPYEMA.**—It has long been known that the pus of acute abscesses contains micrococci, and Ogston, of Aberdeen, in 1880 found, as the result of many observations, that micrococci were always present in acute abscesses, but absent in chronic. Watson Cheyne confirmed these conclusions and explained them by showing that the micro-organisms very soon exhausted the nutritive material in a fluid, and then fell to the bottom and died. "In an abscess they live as long as they find nutriment, and then they die, and cannot be obtained on attempting cultivation, though they may still be seen on microscopical examination." Hence it is plain that the

presence of dead micrococci in pus is not evidence of the special virulence of the fluid in question, but is simply in accordance with the known life history of these organisms.

Further, all who have had much experience of pleuritic effusions will know that the condition of the fluid by no means always determines the state of the patient; that a serious effusion may persist with symptoms that are usually met with in empyema, and that pus may exist while the temperature is normal. I have even seen an intensely fetid empyema in a patient with a persistently normal temperature.

**FALSE RABIES DUE TO WORMS.**—Dr. A. Siltrini (*Lyon Medical*) has observed several cases of pseudo-hydrophobia in dogs, especially hunting dogs in Tuscany, infested with the strongylus gigas. Among the symptoms is a disposition to bite, the animal avoids the light, its mouth is red and frothing, its voice is hoarse, and its gait is vacillating. Its expression is that of suffering rather than of ferocity. The condition is somewhat difficult to distinguish from rabies, but the occurrence of hematuria, from the lodgment of parasites in the urinary passages, establishes the diagnosis. The disease is fatal, except in the rare cases where the worm is expelled from the urethra.

**LIGATION OF COMMON ILIAC ARTERY.**—The common iliac artery was ligated for a large and rapidly increasing aneurism of external iliac by Mr. Clement Lucas, in Guy's Hospital, on June 24th. Owing to the size of the aneurism the abdomen was opened in the median line; on turning aside the intestines the vessel was reached without difficulty through the peritoneum. Neither shock nor rise of temperature followed the operation, and on the evening of June 26th the patient was doing well, the circulation being well maintained in the foot. On July 6th, the British Medical Journal reports that the patient had continued to do well; that his wound was then healed, and that he was considered to be convalescent.

**TREATMENT OF TABES BY SUSPENSION.**—At the last meeting of the Neurological Society of Berlin, Prof. Bernhardt reported the results of two hundred and twenty suspensions in nineteen cases of tabes. He concludes that suspension by means of Sayre's apparatus is a most valuable therapeutic agent in this disease. In almost every case he observed a decrease, if not disappearance, of the lancinating pains, improved walk, a diminution of ataxic symptoms, strengthening of the functions of the bladder, and improved mental and general physical condition.—*Deutsche Med. Woch.*

**REJUVENESCENCE OF THE HAIR OF THE HEAD AND BEARD.**—I wish to mention very briefly an interesting feature or two in the case of a gentleman who has recently been under my care.

Mr. T., who was sixty-five years of age and very tall and slender, suffered for many years from chronic rheumatism of a most painful character. Once he had a severe attack of bronchitis, but he never presented any symptoms of heart, liver, or kidney disease, and his digestion was fairly good for a man who spent most of his time in indoor occupations. Six years ago, when he was well able to attend to his business, he was suddenly seized, without any previous warning, with palsy of the right side, slight deafness of the right ear, and ocular derangement which caused him to see objects double. His speech was not in the least affected, neither had he any appreciable paralysis of the face or tongue. The mind was somewhat confused at the time of the seizure, but it soon regained its usual strength and vigor. The paralyzed limbs, however, never acquired much increase of power, the muscles wasted, and some of the flexors became contracted and rigid. The fingers of the right hand became flexed on the palm, and the fore-arm on the arm. Mobility and sensibility in the limbs were very deficient, but the leg retained more nerve power than the arm. Any movements of the diseased limbs caused a good deal of pain; consequently it was almost impossible to persuade the patient to exercise them either in an active or passive way. A short time before Mr. T. had his seizure a very tall thin man was also attacked with right hemiplegia. In his case, however, the speech was much affected; and, although he is living and in good health, the aphasia and the paralysis have not greatly improved. In both these men the outward and visible signs of paralysis or disease seemed to be precisely similar, and it is only by a knowledge of the locality of the inward lesion that an explanation can be given why it is that in the case of Mr. T. the stream of language flowed strongly and smoothly, and that in the other case the stream is defective, broken, and interrupted. The cause of the palsy in these patients I attribute to embolism, and the great length and the small caliber of the carotids at the necks had something to do, I think, with the formation of the plugs.

But what I wish more especially to mention in connection with the case of Mr. T. is that up to about two years and a half ago

he was both bald and gray haired. About that time, however, dark hair began to grow on the bald patch, and the gray hairs at the head and the beard began to fall and to be replaced by hair also of a dark brown color. These processes of renewal or restoration went on until the hair on the patient's head and chin had assumed the appearance which it had when he was a young man of twenty-five or thirty years of age. His wife and relatives believe that this new growth of hair was caused by chlorodyne, which the patient had acquired the habit of taking in large quantities. Three years ago he was induced by some one to try chlorodyne as a remedy against pain. At first the doses were small and insignificant, but he soon got to take two or three teaspoonful doses of more several times a day. Whether the chlorodyne had any thing to do with the new growth of hair, I do not know. But even supposing it is a hair restorer or rejuvenator when taken in the way that Mr. T. took it, still the remedy is worse than the disease, or, according to the old adage, "the game is not worth the candle," for there is no doubt that when chlorodyne is taken in large doses for a length of time, it produces the most injurious effect on the constitution. — *Dr. William O'Neill, London Lancet.*

**PAPOID IN DIPHTHERIA.** Dr. M. F. Cuthbert, M. D., of Washington, D. C., reports, in the *American Journal of Obstetrics and Diseases of Women and Children*, three cases of diphtheria, in which he applied papoid to the infected area of the throat, and gave of course other treatment. He expresses doubt whether papoid played any part in the removal of the membrane. He adds: "We may have marked local lesions without any prominent local symptoms being complained of, so long as there is the slightest quantity of membrane remaining upon the throat we have reason to fear that fresh deposits may occur." The clinical thermometer is not of any great practical value in diphtheria. It is of far more importance to have a close supervision of the pulse. Of the great value of alcoholic stimulants in these cases there can be no doubt, and the earlier we begin their use the better will our results be. If we were limited to the use of any one agent in the treatment of this disease, alcohol would, I believe, be the most useful one we could select. A moderate dose of that much abused drug—but come the less valuable for all that—calomel, given at the commencement of the disease, will go far toward keeping the digestion in good condition. The disease for a free

administration of nourishing food in these cases is imperative, and, next to milk, a liberal supply of beef juice will best fill this want. Whether papoid be a solvent of membrane or not, I believe it to have two good effects when applied to the throat in a case of diphtheria: (1) It relieves pain, seeming to act more or less as a local anesthetic; (2) it prevents or destroys the offensive odor so common in these cases."

THE MECHANISM OF THE BILIARY SECRETION. — In an interesting paper entitled a "Unique Case of Biliary Fistula," at page 1075 of *The Lancet* of June 1, Mr. Copeman remarks that the secretion of bile does not appear to be continuous, but that "short periods of rest are followed by a flow in a series of jerks, which appear to be caused by waves of peristaltic contraction, occasioned doubtless by the presence of fluid in the gall-bladder and large bile-ducts." As it appears to me that this is a misstatement of fact, originating in an erroneous inference having been drawn from the phenomena observed, and as at the present moment, when the pathology of liver diseases is receiving so much attention from the profession both at home and abroad, it is highly desirable that we should, as far as is possible, possess a correct idea of the mechanism of the biliary secretion, I venture to call attention to the following facts, more particularly as I think they not only give a ready explanation of why the flow of bile is apparently intermittent, but likewise that Mr. Copeman's statement originated in his having simply paid attention to the manner in which the excreted bile entered the receiving-bottle in which it was collected after it had passed along a syphon-tube, instead of observing how it flowed from the biliary ducts themselves. For in the case of a dog with an artificial biliary fistula, which Professor Dastre, of the Sorbonne, has at present under observation in the Physiological Laboratory, if one watches carefully the escape of the bile from the short canula, it is seen that by slow degrees the canula becomes fuller and fuller, until a sufficiency of bile has collected at its orifice for a drop or succession of drops to fall from it. A pause takes place during the reaccumulation of the bile, and then, after the bile has re-collected at the orifice of the canula, the drop-flow is repeated as before. If, however, instead of allowing the bile to flow directly from the canula, a piece of india-rubber tubing be attached to its orifice, and the bile be compelled to flow along it, as in Mr. Cope-

man's case, only the pause in the bile's excretion is observable, and the true cause of the intermission in its discharge from the duct remains undetected. Moreover, the mechanism of the intermittence of the excretion is easily explicable, when one remembers that from the fact of bile being a viscid liquid it takes some little time for it to collect in the canula in sufficient quantity to admit of its dropping from its orifice. The pause in the excretion of the bile seems to be also in some measure due to the intermitting downward pressure of the diaphragm upon the liver and gall-bladder during the inspiratory effort. It may be well for me to state that the dog alluded to was operated on, on March 21, 1889, by the common bile-duct not only being doubly ligatured, but the included part of it being completely cut away, so as to make perfectly sure that none of the bile could by the ordinary channel reach the intestines. And yet, notwithstanding this, the dog—although he had no bile given to him as in the case of Mr. Copeman's patient—has actually increased in weight. For, while before he was operated upon he weighed  $16\frac{1}{2}$  kilog., he now (on June 13th) weighs  $16\frac{1}{2}$  kilog. He has a splendid appetite, and is apparently in perfect health.—*V. Harley, M. B., Lancet.*

THE UNICITY OF BRIGHT'S DISEASE.—Till Johnson wrote, in 1846, "On the Minute Anatomy and Physiology of Bright's Disease," no histological interpretation had been attempted of the lesions described by Bright nearly twenty years previously. Johnson concluded, from numerous careful observations, that fatty degeneration of the epithelia of the kidneys is the principle and essence of Bright's disease; the exudation of blood and serum in the urine is the consequence of the blood pressure augmented by reason of obstruction of the tubuli. Johnson in his first memoir states the view, since then generally adopted by histologists and clinicians, that the divers aspects described by Bright can not be regarded as only different stages of one and the same disease. The small granular kidney has but little similarity to the large, white, soft kidney, and if the name of Bright's disease ought to be reserved for that renal degeneration which begins and progresses by fatty metamorphosis, the white kidney ought to be separated from the atrophied kidney.

Rayer, in France, in ranging his six forms under the common name of albuminous nephritis, though he nowhere says expressly that they may undergo transformation the one into the other, seems to admit that these forms are successive phases of one and the same process.

In Germany the microscope, in the hands of Reinhardt and of Frerichs, confirmed the unicist conception of Bright's disease. Reinhardt attributes the states described by Bright to an inflammatory process which he calls diffuse inflammation. But he thinks that, according to the causes which have produced it, according to the individuals in whom it has developed, this inflammation may follow a different course. He regards the varieties indicated by Bright as the diverse consequences of this diffuse nephritis. Like every inflammatory process, the renal inflammation may present itself to the observer at different periods of the stages of congestion, of exudation with fatty degeneration of the epithelia, of connective-tissue proliferation with ultimate retraction of the tissue of new formation.

Frerichs, in 1851, arrived at the same conclusions. The alterations, he thinks, succeed each other in the following order: In the first stage there is hyperemia with exudation into the renal parenchyma; in the second stage the exudation undergoes varied metamorphoses, which end, in a third stage, in a process of regression and in atrophy of the glandular substance.

In England the tendency to dualism became more and more marked after the publication of Johnson's researches. Samuel Wilks advanced the view that the term "Bright's disease" covers at least two diseases absolutely distinct. He criticised Frerichs' propositions: "If," he said, "the small granular and atrophied kidney is the last stage of a uniform process, of a succession of inflammatory congestions, of exudations and subsequent regressions, with ultimate retraction, how is it that we meet with so few instances of intermediate pathological states? Why has not a single case been mentioned where the symptoms which characterize the large white kidney have gradually undergone transformation, to end in those of the small, granular, contracted kidney? Why is there not a single case on record of the small contracted kidney where acute symptoms preceded the chronic evolution of the disease?"

Wilks constituted two principal varieties, altogether distinct, of renal lesions: the large white kidney, and the small contracted kidney. The causes, symptoms, and course of these two varieties are different. Wilks was one of the first to call attention to the frequent association of the renal lesion with alterations of all the tissues, and in particular of the heart and arteries.

Dickenson placed himself on the dualist side, and divided Bright's disease into two great varieties: (1) *Tubular nephritis*, acute or chronic, which is primitively a catarrhal inflammation of the canaliculi, ending in the large, white soft,

or mottled kidney, and, when the course is sufficiently prolonged, in a certain degree of atrophy; and, (2) *Interstitial nephritis*, in which there is an exudation between the tubules which closes the secreting tubuli and the glomeruli in a gradual destruction of the process, ending finally in the small contracted kidney.

Grainger Stewart, in 1866, adopted a similar division, and insisted that it was more logical to say Bright's diseases than Bright's disease. Jaccoud, *loc. cit.*, the plurality of forms in his *Pathologie Tumorale*, and in his *Formes, Causes et Lésions* in their special treatment. In 1872 Gail and Sutton formulated still other arguments for plurality in the disease, which they formulated as *progressive chronic interstitial nephritis* and its relations with the contracted kidney. Lecorché, in his classical work, *Maladies des Reins*, published in 1875, makes of pathological anatomy the basis of his division. He admits two great varieties of renal inflammations according as the focus of the condition is of the intertubular connective tissue; the first variety constitutes the parenchymatous nephritis, the second, the interstitial nephritis. He also describes mixed forms and insists on the frequent combination of interstitial nephritis with grave or "profound" parenchymatous nephritis; amyloid degeneration is described in a separate chapter. Lecorché would reserve the name Bright's disease for profound parenchymatous nephritis, which presents four periods: a period of hyperemia, a period of hyperplasia, a regress to or fatty period, and a period of atrophy or collapse.

It is significant of the provisional character of the theories hitherto prevalent respecting the renal diseases, that Lecorché, in the recent admirable treatise on *Albuminuria and Bright's Disease*, which he has published in conjunction with Charles Talamon (a work from which we have borrowed in the foregoing exposition), has abandoned the dualist view which he formerly entertained, and has declared himself a unicist. The considerations which have led to this change are very clearly set forth in the second part of his work; they are considerations derived from the more extensive knowledge which the studies of the past twenty years have given of the renal anatomy and histology and clinical history of Bright's disease.

We intend in another number to present the principal arguments which these writers have advanced in support of the dualist view.—*Boston Medical and Surgical Journal*.

GANGRENOUS ABSCESS OF THE LUNG TREATED BY INCISION AND DRAINAGE. Recovery. E. H., a woman, aged thirty-nine years, was seen by me May 18, 1887. In January

tion with Dr. Bindley, of Brighthouse. Her illness had commenced a fortnight before, with feverishness, general malaise, and cough. At the end of a week she got up, but was taken worse the next day with pain in her chest; the cough became more troublesome, and within a day or so the expectoration was observed to be offensive. When I saw her she was very feeble, not very short of breath when lying down, but the effort of sitting up in bed produced both faintness and dyspnea. The pulse was quick, and its rate easily disturbed; the appetite was not bad, and there was no diarrhea; but there was a good deal of perspiration, and the temperature had kept up between 101° and 103°. Her chief complaint was of extreme weakness and of violent attacks of cough, sometimes lasting hours together, and producing only slight and difficult expectoration, which, however, was exceedingly fetid, sickening both her and her attendants. The paroxysms of cough were often separated by intervals of several hours. Below the point of the right scapula there was dullness, not very marked, and not extending quite to the base; and over and around the dull area the respiratory sounds were abolished, except on coughing, when moist sounds were heard, but not very distinctly. During the next month her condition steadily deteriorated, and on April 21st she was found extremely weak, with quick, feeble pulse, frequent perspirations, failing appetite, and constantly recurring cough, with expectoration of a thin yellowish-brown fluid of a very offensive odor, which made the whole atmosphere of the room sickening to a degree. In the early days of her illness the expectoration had occurred at considerable intervals, but now it came on so often that it entirely prevented her from satisfying such little appetite as she had, every attempt to swallow immediately setting up cough, and filling the mouth with this offensive expectoration. There was now distinct gurgling to be heard occasionally below the right scapula on coughing, with loud cavernous cough sounds. The largest quantity of fluid ejected at one paroxysm was about a teacupful. Operation was advised, but was not consented to until May 12th, when her condition had become apparently desperate; coarse moist sounds were audible over the opposite lung, and she was evidently sinking rapidly. An aspirator inserted for about three inches into the site of the loudest cough sounds drew away nothing; but on making an incision into the same spot, and boring inward with a "sinus"

forceps, the blades of which were then opened, it was obvious, from the free mobility of the point and from the expectoration becoming immediately blood-stained, that a cavity had been entered. The opening was then extended so as easily to admit of the insertion of two drainage-tubes, of as large a caliber as would lie uncollapsed between the ribs. There was very little discharge—I should say less than an ounce; but the fetor was extreme, so much so that the smell clung to my hands for many hours, notwithstanding all my efforts to remove it.

From the date of the operation her recovery has been steady and continuous; since that afternoon the expectoration has never again been fetid, and in a very few days the discharge through the tube became sweet, and has remained so. It is curious to remark how small in quantity the discharge has been, and how rapidly the expectoration diminished; it seemed as if the free dependent opening at once removed all the difficulty; the appetite returned, the cough and expectoration diminished, the fetor vanished, and when I saw her last, on June 6th, she was up and walking about. The tube, of course, still remains in place.—*Dr. S. C. Smith, London Lancet.*

**ANTIFEBRIN IN EPILEPSY.**—Dr. Theodore Diller, of the State Hospital for the Insane at Danville, Pa., writes to the *Therapeutic Gazette*, June, 1889, that he has employed antifebrin in nine unselected cases of epilepsy. The remedy was administered three times a day, dry, upon the tongue; and the dose given was four grains, except in two cases in which this amount was doubled. It was given, with more or less interruption during part of October, and all of December, January, and February last. The month of October is not included in his estimate of the effect of antifebrin. Dr. Diller concludes that, in all cases in which the drug was given continuously, there was noted a reduction in the number of fits, ranging from about twenty-five to seventy-five per cent, as compared with other months during which the patients were on the bromides and tonic treatments alternately. The remedy was in all cases well borne, producing no apparent mental or physical depression. This was in marked contrast with the depressant effects noted after a course of bromide treatment. No skin eruption was produced. In any given case, in which a great number of fits are occurring, and where it is desirable to control them as soon as possible, he thinks the bromides would be of far more value than antifebrin.

# The American Practitioner and News

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D. W. YANDELL, M. D., }  
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## SUTURE MATERIAL.

The several substances in general use for sutures are silver wire, silk-worm gut, chromicized catgut, carbolicized catgut, and silk. Of these each has certain merits; all have certain defects. The three first-named materials possess the merit of quick, easy and perfect sterilization. They have the drawback of being wholly incapable of resorption. Carbolicized catgut has the single merit of being quickly resorbed. It is defective in that it can not always, with positive certainty, be made aseptic, and is consequently liable to become itself a source of infection, while the very quality which commends it (ready absorption) is, at times, the chief obstacle to its selection. Silk is capable of easy and perfect sterilization, but while it is finally absorbed, the process is always slow to a degree which constitutes a positive objection to its use.

In No. 24, 1889, *Centralb. f. Gynæk.*, II. Thomsen reports a carefully conducted series of experiments made on rabbits, bitches, and cats, with the view of determining the comparative value, as suture material, of chromic acid catgut, silk, silk-worm gut, and carbolicized catgut. Thomsen summarizes the results as follows:

"1. Silk is the safest and best suture material, because it can be absolutely sterilized, and is time is absorbed.

"2. Chromic acid catgut, silk-worm gut, like silver wire, are incapable of resorption, and ought not to be used.

"3. Carbolic catgut, like all forms of catgut, ought to be rejected on account of the danger of infection. Moreover, carbolic catgut is unfitted for large intra-peritoneal wounds by reason of its rapid absorption."

The above conclusions were drawn from intra-peritoneal operations alone; and, being correct, silk must be given first place as a material for sutures, not only in operations done in the cavity of the peritoneum, but in all other operations as well.

The large majority of American surgeons are of one mind with their German *confrères* in this matter, but the fact remains that the slow way in which silk is absorbed still leaves the ideal suture open to discovery.

## CARBOLIC ACID INJECTIONS IN CARBUNCLE.

More than twenty years ago the late Dr. Nott, of Mobile, then practicing in New York, first used carbolic injections in the treatment of carbuncle. He reported to the New York Medical Journal several remarkable cures. The treatment soon found favor with the profession, and has been much used since. In Louisville it has well-nigh superseded all other local methods. The acid, however, is not used by all in the same way. Some practitioners apply it pure, others dilute it in varying proportions with either water or glycerine, while still others apply it in washes and unguents. The author of the practice used it by injection alone, either hypodermically or, where there were several openings in the carbuncle, by an ordinary syringe. More than once since Dr. Nott's death claim has been laid by physicians here and there, in this country, to the practice, but on proof being furnished of Dr. Nott's priority of title, the contestants yielded with good grace. The Paris cor-

respondent of the Journal of the American Medical Association, July 10, 1889, quotes from the *Journal de Médecine de Bordeaux* two remarkable cures of carbuncle by carbolic acid. MM. Arzonan and Lande, who report these cases, say that one of them was considered hopeless, the carbuncle being of enormous size and on the back of a patient sixty-five years old. The solution used consisted of fifteen parts each of water and glycerine and three parts of crystallized carbolic acid. The injections were made into the cellular tissue of the periphery of the inflamed zone at five different points. The total amount injected the first day represented seven grains and a half of pure carbolic acid. The pain was very severe, but subsided in some hours, and the following morning the local symptoms were better. The parts were injected at three points only the next day, five grains of acid being used. On the third day but four grains were given. On the fifth and sixth days less than two grains were injected. Convalescence now set in and continued without interruption. Notwithstanding the large amounts of carbolic acid applied, the toxic effects were almost *nil*. The narrator states that twenty-four hours after the first injection the amelioration was notable; twenty-four hours later the cure of the patient was assured. MM. Arzonan and Lande regard this case as sufficiently encouraging to make surgeons less timid in the local application of carbolic acid, and warrants, in urgent cases, its very free use.

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#### DR. CHEATHAM.

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Our valued contributor, Dr. Cheatham, who is taking his annual holiday abroad, furnishes on another page an uncommonly interesting letter, written while in Vienna.

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THE State University of Texas will soon have a fine building for its Medical Department. Galveston recently appropriated \$25,000 toward its erection.

## Notes and Queries.

*Editors American Practitioner and News:*

THERE appears to be some uncertainty and hesitation on the part of physicians as to the permissibility of making solutions of different percentages where one ingredient is solid, and to be weighed, while the medium in which it is exhibited is fluid, and to be measured. There is no reason why this difference in system should cause annoyance, as one is readily represented in figures of the other. A fluid ounce of water is equivalent to 456.7 troy grains, or approximately 457 troy grains. Therefore a pint is equivalent to 7,312 troy grains, or, dropping the last two figures, which are not important as affecting the result, 7,300 grains. Given this number as the relation existing between the wine or ordinary pint and apothecaries' weight, it is easy to construct a solution of any strength. For instance, it is desired to make a solution of 1 part medicament to 1,000 parts of water. By dividing the number of grains in a pint by the strength of the solution desired, the quotient will be the weight of the medicament required ( $7,300 \div 1,000 = 7.3$ ). But as .3 equals  $\frac{1}{3}$  nearly, and as few physicians are provided with a weight of this size,  $\frac{1}{2}$  can be substituted without materially altering the result. Hence we have  $7\frac{1}{2}$  grains to one pint of water. The larger denominations (stronger solutions) are attained by multiplying the amount, and smaller (weaker solutions) by division.

As solutions containing varying percentages of cocaine or its salts have come into such general use, a few words as to their preparation may be admissible. Remembering there are 457 grains in one fluid ounce, a one-per-cent solution will require 4.5 grains per ounce. ( $457 \times .01 = 4.57$ ) From this number all higher strengths can be calculated, and, if fractions of an ounce are required, division of the ounce quantity by 8 (number of drams per ounce) will give the number of grains per dram of solution of that strength.

SIMON FLEXNER, PH. G., M. D.

**VALUABLE SUGGESTIONS.**—The New York Board of Health has followed up the report of its pathologists on the contagiousness of tuberculous diseases with the publication of a series of rules to be observed for the prevention of consumption. The first directs that the sputa of suspected consumptives should be received in earthen or glass dishes containing a solution of bichloride of mercury, 1 to 1,000. The other rules are as follows:

2. Do not sleep in a room occupied by a person suspected of having consumption. The living-rooms of a consumptive patient should have as little furniture as practicable. Hangings should be completely avoided. The use of carpets, rugs, etc., ought always to be avoided.

3. Do not fail to wash thoroughly the eating utensils of a person suspected of having consumption as soon after eating as possible, using boiling water for the purpose.

4. Do not mingle the unwashed clothing of consumptive patients with similar clothing of other persons.

5. Do not fail to catch the bowel discharges of consumptive patients with diarrhea in a vessel containing corrosive sublimate one part, water one thousand parts.

6. Do not fail to consult the family physician regarding the social relations of persons suffering from suspected consumption.

7. Do not permit mothers suspected of having consumption to nurse their offspring.

8. Household pets (animals or birds) are quite susceptible to tuberculosis; therefore do not expose them to persons affected with consumption; also, do not keep, but destroy at once all household pets suspected of having consumption, otherwise they may give it to human beings.

9. Do not fail to thoroughly cleanse the floors, walls, and ceilings of the living and sleeping-rooms of persons suffering from consumption at least once in two weeks.

**HARD ON SPECIALISTS.**—Sir Andrew Clark, President of the College of Physicians, London, paraphrases, in a recent address, what was once—a long time now—a capital bit of humor, at the expense of the specialists. The

orator aimed it in this instance at special hospitals: "A doctor who can get on in the ordinary way takes to studying the great toe, and he discovers something about it never before known. In the course of his studies he ascertains that the diseases of the organ are not only supremely important in themselves, but that they have the most intimate relation to all the other serious diseases of the body. He also invents a wonderful instrument whereby he can look into the great toe and see what is threatening, and prevent all those terrible things which happen in the organ and affect the whole system. He goes to his friends, shows them his instrument, and tells them of his discoveries. They then club together and establish a Hospital for the Treatment of Diseases of the Great Toe. They soon get patients who are convinced of the vast importance of the diseases of the great toe. Marvelous cures are effected, and all sorts of frightful diseases are prevented. They have an annual meeting. They have a chairman who sets forth bashfully in the presence of the great physician the diseases of the great toe, the wonderful things that have been done, the service which has been rendered by the hospital, the terrible prejudice it has had to encounter, and the determination that this great institution shall be liberally supported, notwithstanding the prejudices of the medical profession and of those who herd with them."

**SULFONAL.**—In the London *Lancet*, July 13th, T. Lauder Brunton, M. D., says: "Sulfonal appears to be one of the most effective of all the newly introduced hypnotics, and although it does not, like morphine, compel sleep, it induces sleep in a pleasant manner and has few disagreeable effects and little or no danger."

**RAPID WAY OF STAINING THE BACILLI OF TUBERCULOSIS IN TISSUE AND LIQUIDS.**—This method depends on the application of heat and the proper choice of staining agents. The stain is crystal violet (*Karmumethyl violet*), and the preparations are counterstained in eosine. The method of preparing the stain is essentially that of

Von Kühne, of Wiesbaden, and is as follows :

- No. 1. Crystal-violet. .... 1 gram.  
 Alcohol (95°)..... 30 c. c.  
 No. 2. Ammon. carb..... 1 gram.  
 Distilled water..... 100 c. c.

A quantity of solution No. 2 is poured in a dish, and enough of No. 1 added, that a drop of the mixture placed on filter-paper gives a deep stain. This mixture is heated to boiling, and kept at that temperature during the operation of staining. For cover-glass preparations immerse not longer than one minute. Decolorize in ten-per-cent nitric acid for four or five seconds. Wash in ninety-five-per-cent alcohol, and counter-stain in

- Eosine ..... 1 gram.  
 Alcohol (60°)..... 100 c. c.

Stain for half a minute in cold; dry, and mount in xylol balsam.

For Sections: Stain one minute; decolorize in twenty-five-per-cent nitric acid; wash in alcohol; counter-stain in eosine, and mount as before.

This method, besides being rapid, is said to produce brilliant preparations.—*Centralb. f. Bakteriologie and Parasitenkunde*, June 14th.

S. F.

CHRISTIAN SCIENCE.—The Indiana Medical Reporter makes the following suggestions to the disciples of this new craze, which, if adopted, would in some measure atone for the evils they have brought into the world: "Let the Christian Scientists offer themselves (which they will surely for the sake of science, which they love and worship) as subjects for inoculation experiments with some of the supposed germs of those diseases to which animals are not characteristically susceptible. We are very much in need of such great opportunities. Imagine some of the dear Christian Science (which being interpreted means Blasphemous Idiocy) ladies quietly submitting to infection with typhoid, cholera, puerperal fever, and last, but not of least importance, gonorrhea and syphilis! Here is a true test.

At the Johnstown flood six physicians were drowned, and twenty-one lost all they had.

THE next (tenth) International Medical Congress will be held in Berlin. The Congress will be opened on the 4th and closed on the 9th day of August, 1890. Detailed information as to the order of proceedings will be issued after the meeting of the delegates of the German Medical Faculties and Medical Societies at Heidelberg, on the 17th of September in the current year. Meanwhile, we should feel sincerely obliged if you would kindly make this communication known among your medical circles, and add at the same time our cordial invitation to the Congress.

VON BERGMANN,  
 VIRCHOW,  
 WALDEYER.

TENNESSEE MEDICAL EXAMINING BOARD.—The Times-Register says: Tennessee has now a Medical Examining Board, and the Governor with singular good judgment has given to the State Medical Society the privilege of recommending three members of this board, he to nominate the fourth regular practitioner. Elected in such a manner, the board is likely to be both competent and just.

DR. HENRY M. HURD, of Pontiac, Mich., now Superintendent of the State Lunatic Asylum at Pontiac, has been appointed Superintendent of the Hospital of Johns Hopkins University.

PROF. FRANCIS CORNELIUS DONDEERS, the eminent ophthalmologist, died recently at the age of seventy-one.

### SPECIAL NOTICE.

THE Queen has been rather troubled with rheumatism and insomnia again lately. Her Majesty has been ordered to take scarcely any thing besides whisky and Apollinaris, as it is found that that pleasant and wholesome combination is most beneficial to her. The black crutch walking-stick has been painfully *en evidence* since the Queen's return from the North, but except for this Her Majesty's health is as good as it usually is in the summer.—*Lady's Pictorial*, London, July 6, 1889.

BROMIDIA.—I have used the Bromidia (Battle), and the results obtained have been really excellent. It certainly combines all the advantages of other preparations of this nature, while at the same time it possesses none of their disadvantages. The fact that it produces no unpleasant sensation on awaking renders it specially valuable.

DR. LUD. MARC.  
 ST. NAZAIRE-SUR-LOIRE, FRANCE.

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÂ."

VOL. VIII.  
[NEW SERIES.]

LOUISVILLE, KY., AUGUST 31, 1889.

No. 5.

*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we would downright facts at present more than any thing else.—RUSKIN.*

## Original Articles.

### TREATMENT OF ENTERITIS, OR SIMPLE CATARRHAL ENTERITIS.\*

BY JOHN A. LARRABEE, M. D.

*Professor of Materia Medica and Therapeutics, and Diseases of Children, in Hospital College of Medicine, Louisville.*

While no period of life can be considered exempt from enteric and gastro-enteric inflammation, the mortality from these diseases is so widely different as to demand a separate consideration. Few adults succumb even to the most violent attacks, while the very young and the very aged yield up their lives most readily at the very onset. The time taken for my vacation this season was not of my own choice, and corresponded to the period of greatest frequency of bowel diseases in children in Louisville. My knowledge of the mortality during these three weeks is from the daily press and from less pleasant reminders after my return. One of these weeks reported 45 infants below 5 years of age, and another 35. This mortality, more than any other consideration, prompts me to invite your attention to this subject to-night. I shall not attempt, in the brief hour allotted to writing before coming to the meeting, to do more than to introduce the subject as one worthy of your attention, and will ask the president to kindly permit the discussion to take a broader latitude to include the gastro intestinal troubles incident to the summer season.

In many of my families and in the insti-

tutions which are under my care, I left orders that both the water and food of the nursing should be sterilized. In all these, where the advice was followed, no serious bowel trouble has occurred. This fact, if we are warranted in drawing conclusions from so limited data, is in keeping with the now generally acknowledged etiology of infantile summer diseases. A paper, however hurried and incomplete, which should fail to accord first place to micro-organisms as a cause of intestinal disturbances, would be hardly acceptable. Yet I feel that our knowledge of these microbes is not such at present as to cause us to eliminate other causes of acute dysentery. And first and most prominent in the production of catarrhal enteritis is sudden change of temperature, or, in common parlance, "taking cold." No season of the year is so favorable to this cause as the heated term of our summer months. The more nearly our seasons approach to the tropical type the more prevalent is acute enteritis. Such a type of tropical weather we have had for the past fortnight in Louisville. The atmosphere is filled with vapor converted into steam by the intense heat, and acute intestinal catarrh abounds.

The vapor in the atmosphere is at once precipitated upon the rapidly cooling earth and the dew-point is suddenly reached. The semi-nude dress, which has proven so comfortable during the day, is not supplemented at night. Oftener the child falls asleep out of doors or by an open window, while adults sit upon the lawns and steps of their homes until they are thoroughly chilled. Fluxion to the extensive net-work of blood-vessels in the intestines is the natural result, and an evacuation of mucus and blood with tenesmus may be regarded as nature's effort at relief.

\* Read before the Louisville Medico-Chirurgical Society, July 21, 1889.

Acute dysentery in children is also very frequently caused by the retention of ingesta; for example, seeds of fruits, raspberries, blackberries, cherry stones, grape seeds, and even tomato seed, which appear in quantities in the stools. In these obstructive cases a marked tenderness exists over the hepatic and splenic colon. Enteritis is not unfrequently associated with typhlitis in childhood, and a fatal termination is precipitated by true ileus. It has happened to me more than once to see invagination of the intestines treated for days for dysentery.

Not infrequently we recognize a malarial element in the production of dysentery. Exacerbations are noticeable in the frequency of the alvine dejections corresponding to an elevation of temperature. The internal administration of quinine is almost certain, however, to aggravate the intestinal and gastric symptoms. A liniment made by dissolving the muriate of quinine in rectified spirits, with the addition of sweet almond oil, rubbed very freely over the thorax and abdomen of the infant, has been very efficacious in my hands. Indeed I have often been surprised by the prompt action of quinine administered in this manner.

In the treatment of acute catarrhal enteritis, as in other disease of the intestine in infancy, there is good reason to believe that too little importance is attached by the general practitioner to those means outside of actual medication which are essential to the cure, and too much attention is paid to the medication of the little sufferer.

It is quite seldom that we hear careful directions laid down by the physician as regards diet. Certainly nothing can be of greater importance than the regulation of the character of food chyme which must pass over the diseased structures. It should be nutritious. It must be non-irritating. Amylaceous and mucilaginous articles of diet are to be preferred. Barley-water, gum-water, elm-water, toast-water, are sufficiently palatable when properly prepared for drinks, while arrow root, sago, and tapioca, blanc mange and egg albumen are quite sufficient for nourishment. In more ex-

hausted conditions, or in chronic enteritis from necrosis, I have found the consomme with tapioca, prepared by the Franco-American Cooking Company, and malted milk, given hot, to be the best diet. It is quite wrong to think that milk, taken in considerable quantities, is a simple and bland diet, as the retained curds are as objectionable as lumps of potato or beefsteak. Whey with wine may be used for children.

Rest, absolute horizontal rest, is a *sine qua non* in the treatment of all forms of enteritis. It is wrong to place the child in an upright position for stooling. Application of warmed oil, covered by a thin layer of absorbent cotton to the abdomen, is productive of so great comfort that it ought not to be forgotten in the directions at bedside. Often a thin flaxseed poultice is more comfortable, and when the pressure is no objection it may be used. I much prefer to pack the abdomen with a towel wrung out of hot water protected by oil-silk covering.

I have adopted a routine treatment for all cases of acute enteritis and gastro-enteritis coming under my care. This treatment consists in a thorough, free evacuation of the whole intestinal tract by saline or oleaginous cathartics. Salines preferred, and among the salines preferred, Rochelle salts. A solution of magnesia sulph. in compound infusion of roses (U. S. P.), with a drop of laudanum to the dose, is a very palatable and effectual treatment, and with it alone I have accomplished the cure of some bad cases. Whenever from any cause, more often by getting a case after treatment had been begun, I have omitted the evacuant treatment at the commencement, I have invariably been obliged to return to it before getting relief.

I think that medicine owes something to surgery for removing the prejudice which used to obtain in the use of purgatives in intestinal and peritoneal inflammations. If I mistake not, it is the custom of these gentlemen to give free catharsis so soon as surgical peritonitis threatens, and with good results. It used to be considered that nothing but immediate and full doses of opium

could be relied upon to check the progress of such inflammation.

Bromide of sodium in full doses of 10 grains for infant, given in syrup acacia, repeated quite often, not only secures rest, but has proven a most excellent remedy, being sufficient to cure some cases without any other treatment. Whenever the stools are at all malodorous, naphthol or salol may be used. These are both good agents, and have proven of great service to me in arresting diarrhea due to fermentation and putrefaction, often in a very prompt manner and in very few doses. The combination of carbolic and salicylic acid is a very happy one. In gastro-enteritis carbolic acid with lime-water is good treatment. Also soda salicylate with syrup of cinnamon acts as by magic in same class of cases; it must not be continued if the relief is not immediate.

As to the use of opium in enteritis of infants, the teaching in general practice that opium is the sheet-anchor of safety needs to be largely modified. I must confess to a very lively fear, save in the very cautious use of this drug to control peristalsis. In cholera infantum no treatment can compare with the hypodermatic use of morphina and atropina. Since I adopted this treatment, about ten years ago, I have had most marked success in saving my cases of this truly dreadful disease. I never give any other treatment in the stage of collapse, and seldom repeat the injection, because if properly dosed to suit the age it is sufficient to restore the capillary circulation, change the osmosis, and rescue the patient from the grasp of death. After this has been accomplished, calomel or bichloride in very minute doses is of very great service in establishing the secretions. The infant must not be returned to the breast or milk-bottle for forty-eight hours, barley water being used as a substitute to rest the stomach.

The advantages which I claim for this treatment are: (1) The certainty of the absorption of the drugs. (There is no absorption from the digestive track in cholera). (2) The certainty of the patient receiving the proper dose. (The internal administra-

tion of these agents in vomiting involves a degree of doubt as to the quantity remaining, and possibility of poisoning soon puts the doctor at sea without a compass in the case.)

The chief source of danger in the administration of opium to the infant lies in the repetition of the dose at too frequent intervals. I have repeatedly seen infants dead of opium where no unfavorable criticism could be made as to the individual dose, but the order to repeat every two hours did not admit of elimination; in consequence, a gradual and fatal narcosis resulted. I prefer to use what opium or morphia may be necessary at my visits rather than leave the dosing to the family for twenty four hours.

For many years I have used nitrate of silver in the treatment of enteritis infantum, and the result has been to the greatest degree satisfactory. As a microbicide it is second alone to mercury. Its therapeutic value is in proportion to the chronicity of the disease, although I have by no means limited its administration to that stage of enteritis, frequently commencing it immediately after the evacuant treatment so essential to the first stage. In those distressing cases where proctitis is added with tenesmus and prolapsus, large dilute injections of argent nit. crystals, gr. x to Oss. of distilled water produce a magical effect. In the use of the nitrate I recognize other therapeutic properties than astringent and germicidal. The action of the salts of silver and gold upon the nervous system are hardly less valuable. Cases treated with the salt of silver are less frequently followed by marasmus, so dreaded a sequence of enteritis.

If the number of cases of simple atrophy, which drag along and die in the early autumn succeeding their summer diarrhea, could be properly tabulated under the head of chronic enteritis, we should have a better conception of the mortality of simple catarrhal enteritis.

The daily inunction of oil, any clean oil, finely chopped raw beef, and the small doses of silver, copper, or gold, will often yield noble results. It is quite neces-

sary, however, to guard any favorable prognosis, because of the liability to intercurrent disease, especially hypostatic pneumonia, of which the largest proportion of atrophied babies die. Cases in which the lachrymal secretion is present, and in males where the cremaster muscle contracts, upon irritation of the inner aspect of the thigh, will admit of a favorable prognosis, notwithstanding the extreme atrophy; but those in whose eyes are floating flakes of lymph like buttermilk will surely die. In the convalescence from an attack of enteritis no medicinal agent has done more than the pernitrate of iron given with an additional drop of dilute nitric acid, or a syrupy solution of the pernitrate. Also, the tincture ferri chl., with gentian elixir, as prepared by J. Wyeth or Eli Lilly, in small doses three times a day.

I can not close this hasty synopsis of my treatment of enteritis without paying just tribute to chloral hydrate. From two to five grains of chloral are dissolved in a table-spoonful of elm, or starch, or barley-water, and thrown into the rectum with an infant's syringe after each action, always waiting a few moments for tenesmus to subside so that it may be retained. The rectum for medicine and the stomach for food is much better policy than the reverse of this, which is commonly followed.

LOUISVILLE, July 19, 1889.

### ON RICKETS.

BY H. C. DEMBITZ, M. D.

There seems to be a general impression that rachitis is a very rare condition in this part of America: common in other lands, seldom seen in this. I first began to see these cases at Dr. Forchheimer's clinic, at Cincinnati, while I was a student of medicine in that city. Dr. Forchheimer was a pioneer in America in this line of work. Having seen hundreds of cases abroad, he looked for them in Cincinnati and found them in numbers. He exhibited cases of the disease in its different phases almost daily at his clinic, and in the course of the session gave several exhaustive lectures on the subject. Going abroad the following year, I saw very

many cases at the children's clinic, in Vienna. I chanced to see more, perhaps, than usual, because Kassowitz had just then published his results in the treatment of rickets by phosphorus, a treatment which excited much discussion and led to many experiments. On my return home I met with cases of rickets in my own practice, and it has been a matter of surprise to me to hear physicians, who do a large business among children, say they had never seen a case of rickets, and others who, at the most, had seen but one or two cases.

It is well, just here, to ask, What is this disease? Why is it overlooked? And how far is it properly treated without being diagnosed? Rachitis or rickets is a systemic disease of early infancy, in which the most significant anatomical changes are found in the skeleton. The shape and structure of various bones are changed, and, as a result, serious alterations in the form and size of certain cavities occur, whereby the organs which they contain are interfered with. The symptoms during life, as well as the lesions found *post-mortem* in the skeleton, will depend on the period at which the process begins. The bones affected are, as a rule, those in which at the time the growth is normally most rapid. If it begins during the first three months after birth, the skull suffers most changes. The fontanelles remain wide open, and the sutures do not close; may be even wider than at birth. In other parts, as the occiput, bone already formed may be rapidly absorbed, leaving but a parchment-like membrane to protect the brain (cranio-tabes). Over the frontal and parietal protuberances there is a proliferation of cells, osteoid tissue is formed in excess, does not ossify, but gives the head a peculiar, square shape. This when the process begins early. Then, too, the first year may pass without the first tooth appearing.

If the disease begin later, the fontanelles are perhaps closed already. The natural growth here is less rapid. This is the time for the chest to expand, and for other long bones to grow in length and thickness. The disease, beginning now, attacks these bones with resulting deformities, shortening, bending, thickened epiphyses, narrow chest, and deformed pelvis.

The increase in length ceases or becomes very slow. The radius and ulna, tibia and the ribs exhibit knobs at their ends. The rachitic rosary is the row of knobs thus formed by the ends of ribs at the costo-chondral junction. The ribs remain short and soft, the chest narrow. As a further result of this the thorax is too small, liver and spleen are pushed down. This helps to form the large belly (which is principally due to distended intestines), and this large belly, in contrast to the small chest, gives the infant a frog-like appearance. These conditions of the skeleton, the large head which expands with the growth of the brain while the face is comparatively pinched, these bones growing slowly; the wide fontanelles; the short, perhaps curved long bones, with enlarged epiphyses; the chicken breast with rachitic rosary; more or less of these, together with the pallor and malnutrition of these subjects, would seem to be enough for a diagnosis, and yet even typical cases are often not diagnosed. And why? The condition of malnutrition is recognized; the accompanying diarrhea, dyspepsia, the intestinal catarrh as the cause of the tympanites; the whole trouble attributed to improper feeding and bad quarters, and the treatment is accordingly.

Yet if the condition is a special disease, it should be recognized as such. Proper feeding and care may be the most necessary elements of treatment. They undoubtedly are; so they are in the large majority of cases, especially of chronic diseases on the one hand, and in all diseases of digestion. Yet that does not lessen the importance of recognizing rachitis as an entity, and studying its etiology, pathology, and treatment, especially since phosphorus is now held by many to be almost a specific for the bone lesions—and phosphorus is hardly a remedy which would be given in mere disturbances of digestion. This suggestion has been thrown out here in answer to several physicians who have insisted that, whether they diagnosed the condition or not, the treatment was the same as that of the digestive disturbances.

Too much stress seems to be laid on improper feeding as the cause of rachitis. The disease is found oftener in hand-fed than nursing babies it is true, but the latter are not

exempt. The disease is also attributed to unhealthy lodgings, and it is an undoubted fact that they have their influence, but well housed, well-nursed children seldom show signs of rickets, though the cases are rarely so severe as those among the poor; cases are found in the country as well as in large cities. Syphilis, tuberculosis, scrofula have all been named as causes. So, also, rickets follows after acute fevers. These diseases are undoubtedly but predisposing causes, as is any influence which results in weakening the body. The disease is very rare in warm steady climates, and unknown in the tropics. There are worse lodgings, more vitiated air, and certainly as many or more digestive disturbances as a result of improper feeding and spoiled milk here, and yet no rachitis. These facts seem to me almost to force on us the conclusion that bad feeding and malassimilation, just as cachexia resulting from other causes, only predispose to the disease, the cause of which it would seem we must seek in cold, damp, changeable climates. It may be that heredity is a also predisposing cause. It has been urged that the disease is hereditary on the ground that at the American clinics nearly all the cases seen are in German, Bohemian and Irish families. But native white Americans do not frequent clinics, and among the negroes there is plenty of rickets.

Whatever the cause, whether it be changeable climate, certain kinds of climate, certain waves of temperature, moisture or barometric pressure, the manner in which they cause the disease is very obscure. Any number of theories have been adopted and discarded; a similar condition of the bones has been caused artificially, and yet we can not say we understand it. The growth of bone is quite a complicated process. A long bone, as is well known, grows in length in cartilage from three centers—one in the shaft, and one in each epiphysis—and in circumference from the periosteum. There is a zone at each end, between diaphysis and epiphysis, where the cartilage cells arrange themselves in rows; where lime salts are deposited; where these cells then change to bone-forming cells, and vessels appear; and when the process is complete the cartilage is not calcified

but ossified, the homogeneous cartilage is changed to bone with its canals, concentric circles, vessels, etc. While these cells are forming bone, and the periosteum is laying down new layers of tissue which are also ossifying, other cells are always absorbing and destroying, and so, while the length and circumference grow, the marrow canal and those that lead into it are also increasing proportionately.

In rachitis the equilibrium is entirely disturbed. All the cells seem to be spurred on to greater activity. But, while osteoid tissue is formed at the ends of the bones by proliferation of cartilage cells, there is a failure to form bone; the lime-salts are not deposited regularly, and the zone of preparation is longer than normal, but it fails to form bone; it grows in breadth and forms swellings at each end. In the meanwhile the osteoclasts absorb trabeculæ already formed, and the bone becomes porous, light and soft, easily bending or breaking. The process has some similarity to osteomalacia in the adult, but it is not the same. The effects of rickets are seen at all ages, but the disease rarely begins after the third year, and is much more common during the first and second year. In the head the same absorption of bone causes the wide fontanelles and craniotabes.

The results must be again referred to briefly. Deformity which results in narrow chest and narrow pelvis will last for life. These deformities are partly due to mechanical causes, and this is another reason why it is important to recognize the disease. Those holding infants under the arms help to compress the chest laterally. Attempts at walking or kicking, and pressing against the bottom of the bed has its influence on the shape of the soft bones of the pelvis. Moreover rachitic bones are hyperemic and generally hyperesthetic, and that is the reason why these infants are cross, do not want to be handled, and cry when lifted up.

The pathological anatomy of rachitis is confined to the bones. That is, the lesions here are pathognomonic. The accompanying changes in various organs are not different from those caused by other diseases. So there is nothing distinctive in the dyspepsia or diarrhea or in the bronchial catarrh of rachitic children. An

exception may be made in regard to spasm of the glottis, which is confined almost entirely to rachitic subjects, and perhaps to hypertrophy of the cerebrum, which is met nowhere else.

Many theories have been invented. The lactic-acid theory has been given up by most authorities, as free lactic acid can not be present in the blood to dissolve out the lime salts, as this theory supposed.

Chossat's experiments pointed out insufficient lime salts in the food as the cause. Roloff held the same theory, making numerous experiments. He found that all animals receiving food with insufficient lime had rickets.

Wegner found a new relation between lack of lime and rachitis. Wegner had discovered in phosphorus a specific influence on the bone-forming tissues. He gave phosphorus and very little lime in the food, producing artificial rachitis, the characteristic proliferation of cartilage without the ability to complete the process of ossification. It was claimed that the urine of rachitic patients contained more lime salts than that of healthy infants, but analyses by Neubauer and others have shown that this is not true. The feces, however, do contain more lime salts than normal. That is, the lime salts in the food are not absorbed. Is this because in improper shape or because the digestive organs do not act? In cow's milk, for instance, the lime salts are much less easily assimilable than from woman's milk. But on the other hand children at the breast also suffer from rickets.

Roloff regards the disease as due to the lack of lime salts, while Wegner, as indicated, regards the undue proliferation of the cartilage or membrane as primary. The former accordingly would make the disease a disturbance of nutrition simply; the latter in effect a constitutional disease. The latter view seems to me to be more in accordance with the facts.

After causing rickets by allowing insufficient lime in the food, and by small doses of phosphorus, it may to some be suggestive of homeopathy that phosphorus is now the great remedy for this disease. It is given either in solution or in an oil, as cod-liver oil, or, to avoid mistakes due to the improved nutrition from the oil, it may be prescribed thus:

Phosphori.....gr.  $\frac{1}{4}$ ;  
 Carb. bisulph.....gtt. vj;  
 Aq. dest..... $\mathfrak{z}$ iv. M.

Teaspoonful daily, or half as much twice daily, after feeding.

The results are particularly good after the first year, and under this treatment the Germans, who have used it in their clinics for several years, report renewed growth of long bones; the ribs grow and the chest expands; the teeth appear; fontanelles close, and cranio-tabes is cured, and thus the whole condition is often changed in four to eight weeks. And that, as Toplitz remarks, "without change of lodgings, which is impossible in polyclinic cases." Up to the time when phosphorus was used, general tonics—iron, cod-liver oil, arsenic, and improved feeding—had been generally used. The last named is, of course, important under all circumstances.

The disease itself does not result in death except through the complicating dyspepsia, diarrhea, bronchitis, or spasmus glottidis. The danger lies in the changes in the skeleton, some of which it is difficult and others impossible to correct after the disease has run its course. The narrow breast and deformed pelvis belong to the latter group. The curved and crossed legs orthopedic surgeons see often enough. If I may be allowed a brief *résumé* of pre-ent views, as nearly as authorities are united, I should say:

First: That the disease is very common all over the temperate zone, especially so where the climate is damp and variable, and particularly among children living in damp, cold quarters, and begins oftenest in fall and winter. Ritter, in Prague, said thirty-one per cent of his polyclinic children were rachitic, and Hensch, further north, at Berlin, says his figures are higher.

Second: Any cause that weakens—first of all, bad feeding—predisposes to the disease. (Some still regard this as the prime cause.) So also chronic diseases and acute febrile diseases are likely to be followed by rachitis in infants, if convalescence is not prompt.

Third: The characteristic process is in the bones, but the cause of this process is not yet understood.

Fourth: The cases should be readily diag-

nosed; pressure on the sides of the thorax, walking, and other mechanical influences likely to increase deformity should be avoided.

Fifth: When the infant can go to a balmy climate, that would perhaps be best; otherwise, dry, warm quarters and good feeding should be ordered if possible.

Sixth: Besides these, if possible—if not, without them—administer phosphorus, and in some cases iron, in others pepsin, or similar remedies as indicated. Lukewarm washing, gradually cooled off, and brisk friction afterward improve the circulation, and the function of the skin.

LOUISVILLE, KY.

### GANGRENE OF LUNG? A CASE.

BY R. W. FRYMIRE, M. D.

Mr. R., æt. twenty-seven years, up to three weeks before I saw him was going about a fairly well man. His mother died of pulmonary phthisis. For two weeks after going to bed his appetite had kept good. He then experienced extreme difficulty in swallowing. At the time I saw him he had no cough, but was emaciated to the last degree; had high fever; pulse frequent and thready; features sunken; expression haggard; voice a hoarse whisper; the fetor of his breath characteristic of gangrene and almost insufferable. Recognizing that death was near and inevitable, I contented myself by giving a hypodermic of morphia and atropia, which seemed to bring rest and comfort until his death, which occurred a few hours later. I made no *post-mortem* examination, yet I am of opinion that the case was similar to the seventeen cases collected by Paget, wherein the predisposing cause was hereditary taint conjoined to "defect of nervous energy and constitutional debility," while the exciting cause was obstruction of some artery of the lungs by an embolus.

PATESVILLE, KY.

ORRIS ROOT IN AMERICA.—A large quantity of Florentine Orris (*Iris Florentina*) has been found growing in South Carolina, and efforts will be made for its collection. This article has hitherto been unknown as growing within the limits of the United States.

## Societies.

### LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, July 21, 1889.

Dr. W. O. Roberts reported a case of oöphorectomy. The patient, twenty-two years of age, had been married eighteen months. She had always suffered some pain with each menstrual period. Shortly after her marriage she was attacked with severe pain in the left side, the region of the left ovary being very tender to the touch. This attack kept her in bed two months. After this time she went about with constant pain, being compelled to take her bed at each menstrual period. During the past eight months she has been confined to her bed nearly all of the time. In addition to the pain and tenderness in the left iliac region, there were present the usual hysterical symptoms.

Combined manipulation revealed great tenderness in the region of the left ovary, whether pressure was made over the abdomen or through the vagina. The ovary of this side was found to be enlarged. From the vagina there was a muco-purulent discharge which at times was said to be large.

In doing the operation the rules laid down by Tait were followed. The abdominal incision did not exceed two inches in length. The left ovary was found bound down by adhesions; these were carefully broken up. The fallopian tube was enlarged and contained pus. The right ovary was normal. Both ovaries and tubes were removed, the ligatures being applied close to the cornua of the uterus.

The operation was done ten days ago. The patient has done uninterruptedly well. Two days after the operation, which was done two weeks after the last menstrual period, there was a flow of blood from the womb lasting three days. The speaker had noticed this phenomenon in five of his previous cases. The speaker, when asked if removal of the ovaries tended to lessen sexual appetite, said that the present case was the only one in his practice wherein it would be practicable to

gain information upon the point, his former cases having been represented by widows or virgins. In reply to the question as to the effect of removal of the ovaries upon the mind, Dr. Roberts said that the statement had been made that ten per cent of the patients operated upon had become insane. No such result has yet followed in any of his cases. He is of the opinion that many of the patients requiring oöphorectomy are already hysterically insane.

#### DISCUSSION.

Dr. J. W. Irwin\* thinks the hemorrhage which followed upon the operation a matter of no importance. He said the hemorrhage was probably due to an increase of blood in and about the textures of the womb, necessarily following the use of the surgeon's knife, giving rise to engorgement of the uterine mucous membrane and its appendages very similar to the phenomena found in those parts during normal menstruation. He did not regard the discharge of blood as a menstruation, but thought it, more correctly speaking, a hemorrhage.

Dr. J. A. Larrabee thinks that the operation has seen its best days, not on account of loss of sexual desire, but because it is probably resulting in a moral insanity.

Dr. Cecil said that he favored the use of the Staffordshire knot in treating the pedicle; considered it convenient, rapid and safe, giving good control of the stump for cautery, or any other treatment desirable. In regard to the appearance of the menstrual flow for once or twice after operations on the ovaries, he thought, in some instances, the irritation produced by the operations upon the pelvic organs might account for the return of the flow, and in other cases it might properly be attributed to what is known as the "menstrual habit."

Dr. Cartledge thought the bloody discharge from the vagina, almost always occurring a day or so after the operation, should not be considered a true menstruation. Where menstruation persists after the operation, he could not agree with Dr. Cecil that habit was the cause. It is very probable in such cases that a small portion of ovarian tissue has been left, generally as a result of placing the ligature too close

to the ovary before cutting the appendages away.

Dr. H. K. Pusey said that neurotic females were more subject to the conditions requiring oöphorectomy, and that this, with the effects on the constitution of previous uterine and ovarian diseases, was sufficient to account for any increased per cent of insanity that may have been noted among the subjects of the operation.

Dr. John A. Larrabee read a paper on Treatment of Enteritis, or Simple Catarrhal Enteritis. (See page 129.)

#### DISCUSSION.

Dr. Irwin has seen no cholera infantum this year. Has seen a good many cases of gastro-intestinal catarrh, due to fermentation and decomposition of the food. Very little medication was found necessary. The bowels were freely evacuated at first by some mild laxative, such as castor-oil. Their diet was regulated, the food consisting of barley- or rice-water only. Where further medication was required, a few doses of the following mixture, for a child one year of age, usually gave relief:

Tinct. opii deod. .... gtt. xv;  
Acid. bor. (Squibb's) ..... grs. xx;  
Aq. menth. pip ..... 5ij.

M. S: Teaspoonful every two or three hours.

Dr. W. L. Rodman thought the paper very opportune at this time of the year, when children are so liable to such troubles. The few who have come to this meeting in spite of the inclement weather to-night are more than repaid for having done so by the excellency of the paper. The speaker considered it of the greatest importance to withhold *all food* for at least twenty-four hours. Nothing should be allowed but water. Parents will resist this course, but nevertheless it should be adhered to. He preferred to begin the treatment with a purgative, so as to get rid of all irritating matter in the intestinal tract. For this purpose he thought calomel in small doses preferable to any other treatment. He could not understand why Meigs and Pepper, and some other authors, but especially the former, inveighed so against the use of calomel in these cases.

Has never used hypodermic injections of morphia and atropia, but is favorably impressed with the treatment. In all instances he prefers hypodermic medication in the adult when it is practicable. It is the only exact method of medication. It is far more important to be exact in dosage when you are treating infants; therefore the speaker would approve of the practice, and the indorsement given it by Dr. Larrabee is enough to make him use it with the first opportunity offering.

Dr. Cartledge thought the paper one of the most interesting and instructive that had been read before the Society. Had never used the hypodermic syringe in infantile practice, but was accustomed to giving morphia and atropia in very small doses, by the stomach, in cases of cholera infantum. Was very partial to the free use of ice in those cases, permitting the child to suck a piece of ice wrapped in a cloth. For the subacute form of intestinal indigestion, which so often succeeds the acute attack, small quantities of whisky and ice-water frequently repeated seemed of great benefit.

In closing, Dr. Larrabee said the discussion convinced him that it was a great mistake to prepare a paper hastily. He had devoted an hour, perhaps an hour and a half, before coming to the meeting, to the subject of enteritis infantum, and had left out nearly all that he desired to say. He was, however, gratified that the Fellows had entered so freely into the discussion, and considered that an hour had been profitably spent. In regard to fresh air, change of air, etc., he considered that in all cases of bowel trouble, especially those assuming a chronic character, no treatment by a physician can at all compare with the benefits of pure fresh air. It is not so much the removal to a distant point, but a removal from the poisoned, vitiated, stifled air of rooms into the open air, that is needed, the slightest change being sufficient to insure an improvement, as in invalids a change of apartments in the same house often is beneficial. But for these farlorn cases of summer diarrheas and wastings there is nothing that can compare with the river excursions, given under the management of the Louisville Times, and contributed to by our prosperous leading merchants and politicians

He was the originator of this scheme, and was glad that he had lived to see the fruits of his feeble efforts, commenced some fifteen years ago, and he hoped that these fresh-air excursions had now become a fixture in the progress of our great city, as they are in New York and Philadelphia.

In regard to the use of calomel, he thought that the experience of all the members was a unit. There is no one agent so reliable as calomel. He thought the change in the color of the stool in cholera, restored to yellow color, as stated by Dr. Wilson, was certainly a good indication of recovery. The *old-time* doctors felt confident that the case was safe if calomel would only act, and by acting they meant the production of a bilious stool. We give calomel as did the fathers in medicine, but in all probability our explanation of its *modus operandi* in cholera and choleraic diseases is the correct one, and was unknown to the practitioner of the past generation. Then it was given to "*move the liver*," now to destroy the micro-organisms which are at the bottom of the whole trouble. He believed that the truth will remain and be continually strengthened by scientific research. The green spinach stools, and the putrid stools, and the choleraic stools are all the product of micro-organisms which calomel or corrosive sublimate is potent to destroy, and no matter from what standpoint the dose be given, the effect will be the same. The old administration was empiric, and often hurtful; the modern is scientific, and therefore not carried to an injurious extent, minute, subdivided doses acting much better than the enormous doses formerly employed.

Dr. Irwin: Is it not a fact that the English Commission of Physicians reported that calomel had no especial action upon the liver?

Dr. Larrabee: Yes; the Commission so reported. And if a hundred more commissions should be appointed and so report, it would not have the slightest effect upon the practitioner who sees every day, from small, non-purgative doses of calomel, a restoration of bile in the stools. There can be no doubt that calomel has a chologogue action.

Dr. Cecil: How should the infant be clothed in summer?

Dr. Larrabee: In indorsing the microbic origin of enteritis it is not intended to obliterate other causes which may be considered predisposing or contributory, and certainly heat is a potent factor in producing that debility of the digestive organs which renders the stomach powerless to correct or destroy these poisons. We all appreciate this in the heated term, and we lessen our diet of solids, and increase our quantity of liquids and ices, so that our diet, by our own choice, is suited to the lightest digestion possible to be performed. Not so with the infant at the breast. If its thirst is increased, it gets more solids and less liquids—*milk is here spoken of as a solid*—its body and limbs are wrapped in flannel and it is rocked to and fro, not in the "cradle of the deep," but in a very deep cradle, in a hog-wallow out of which it can not possibly roll. Shed the flannel petticoat in June, or as soon as the approach to the nineties is felt; place a gauze-flannel slip over chest and abdomen—legs and feet bare; a short slip over all is sufficient; a bath morning and night of tepid water; occasional salt baths, oiling skin with oil of almonds, and a renewal of the cover in sudden changes, as rain showers, night winds, and cold days, or, in other words, as the judgment of the mother will dictate. Heat is a great factor in the production of bowel troubles, and we recognize the existence of a thermal diarrhea. This is something in the order of sunstroke; skin very dry and burning, 105° and over, with diarrhea. All treatment required is the wet pack and cool shower-bath.

Dr. Cecil said that, of the many good things mentioned by the essayist, none was of more importance than that which referred to the prompt and early evacuation of the bowels. He considered it imperative. Almost without fail, when this measure had been omitted in the management of these cases, he had had reason to regret it, and generally had found it necessary to retrace his steps and do at last what should have been done in the beginning. It makes little difference whether castor-oil or the salines are used. When the bowels are cleared of offending contents, and close attention is given to diet, the key to the situation is well in hand.

In many cases a change of atmosphere is essential to the well-being of these little sufferers, to maintain what is gained by medication and proper feeding. This leads to the remark that the only thing omitted by the essayist is the truly wonderful effect of fresh, pure air, especially referring to the fresh-air excursions on the river given to the poor children of the city, the good results of which are known to none better than the essayist.

He believed the hypodermic exhibition of morphine an admirable treatment in cases presenting desperate aspects. Was glad to hear additional testimony in its favor.

T. H. STUCKY, M.D.,  
Secretary.

### Abstracts and Selections.

**RESECTION OF VERTEBRÆ.**—Dr. Dawbarn, of New York, has reported a case of resection of the spine for fracture. The patient was a man, aged twenty-nine, who sustained a fracture of the spine involving the eleventh and twelfth dorsal vertebræ. He was immediately treated with plaster splints, but he remained paraplegic, and when he came under Dr. Dawbarn's treatment there was complete paraplegia, beginning a few inches below the ribs; involuntary passage of feces; retention of urine, and cystitis, with overflow. The back showed a kyphotic twelfth dorsal spinous process, and the eleventh was deflected to the left about one inch, and somewhat flattened down. There was complete anesthesia as high as the umbilical level, except over the toes and front of the feet, where tactile sensations were very imperfectly perceived. After a month's delay, to allow a thorough trial of electricity, it was determined to expose the spinal cord. Operations on the cadaver in this situation (dorso-lumbar junction), led Dr. Dawbarn to adopt an H-shaped incision; the vertical strokes, as they were deepened, were directed obliquely inward toward the median line, and the laminae were sawed through with Hey's saw directed inward toward the middle line; the upper flap was then turned obliquely upward, and the lower flap obliquely downward. The laminae of the eleventh dorsal vertebra was firmly adherent to the theca, and was removed piecemeal with great difficulty. It was then found that the vertebral bodies had been displaced at this level, so that the cord made an angle of about fifteen degrees with its apex backward; the intention to replace the spinous processes was therefore abandoned, and the posterior arches of the tenth, eleventh, and

twelfth dorsal vertebræ were dissected away. The operation took three hours. The wound, which was dressed antiseptically, soon healed. A note made ten weeks after the operation shows that the patient was improved in certain respects; he had ceased to suffer pain in the spinal column, which had previously been severe on movement; he had regained some power over the bladder and rectum; the muscles of the lower limbs responded more readily to electricity, and he had regained some power over the sartorii. The legs, which had been generally blue and cold, became warm a few hours after the operation. In commenting on the case, Dr. Dawbarn refers to the remarkable series of cases mentioned by Dr. William Macewen, in his address to the British Medical Association, at Glasgow last year; one of those operations was for a lesion very nearly in the same situation as that in Dr. Dawbarn's case, and the benefit derived from the operation was very remarkable. The long delay—six months—in operating in Dr. Dawbarn's case materially diminished, as he points out, the patient's chances of recovery. He urges that whenever, following traumatism, even a slight abrupt irregularity of the spinal column is observed to co-exist with paraplegia from this level, a cutting operation is indicated to determine whether the paralysis is not, by bony pressure, made incapable of spontaneous relief. This operation should be deferred no longer than recovery from the original shock of the injury demands. "If needed at all," he writes, "it is needed early; and we make a mistake if, as in my case, we wait until electricity and time have alike proved futile before attempting what I may call exploratory resection."—*British Med. Journal*.

**THE TREATMENT OF HIP DISEASE.**—Mr. Howard Marsh (*British Medical Journal*, August 3, 1889.) draws the following conclusions in regard to hip disease when it is treated by continued rest, and without operative interference except the opening of abscesses as soon as discovered.

1. In the first place, the anticipation which would naturally be entertained that suppuration adds largely to the immediate danger of the case, and is injurious to the ultimate condition of the limb, is confirmed. In the stage at which cases are brought to the hospital suppuration is either already present, or it occurs after admission in about half of the total number of patients. In the previous report the proportion of suppurating cases was much higher (69 per cent.), and this decrease is a source of marked improvement in the general result.

In order to prevent suppuration it is of

the highest importance that the disease should be recognized early, and be treated while it is still incipient. The more perfectly these conditions are fulfilled, the more limited will the proportion of suppurating cases become; and it is in this direction that the greatest improvement in the treatment and results of hip disease will, in the future, be attained. His own estimate, from what he has seen in the hospital and elsewhere, is that the formation of abscess may be averted by early treatment in at least 80 per cent of the total number of cases.

2. In suppurating cases, which recover, about 65 per cent are good, and 35 per cent moderate cures. The average shortening is one inch; 50 per cent are movable and 50 fixed; 65 per cent walk well, and 35 indifferently.

3. In cases without suppuration which get well, 77 per cent are good, and 23 per cent moderate recoveries; the average shortening amounts to two thirds of an inch; 50 per cent are freely movable; 25 per cent have slight movement, and 25 per cent are fixed; 80 per cent walk well, and 20 per cent indifferently.

4. The mortality due to the disease, as far as it can be ascertained in the cases he has reviewed, amounts to about 6 per cent, or if a wide margin be allowed for cases that may have ended fatally since they were lost sight of, although when they were last seen they were doing well, it may be safely said to be well under 10 per cent, while the mortality from general tubercular infection arising from the joint disease as a primary center is well under 5 per cent.

A question that may naturally present itself is whether these figures are representative, or whether they are exceptional, and such as would not be confirmed were more witnesses taken into account.

He believes, from all he knows of the subject, that they may be accepted as typical; and he adds his conviction that the next group of a similar or larger number of cases that is published will show, not only as good, but still better results.

Now, if we place the results of excision, so far as they have been recorded, side by side with the results of continued rest, he thinks there can be no doubt as to the conclusion at which we must arrive. Mr. Barker last year dwelt emphatically on the necessity of reducing the mortality attending tubercular joint disease; but the figures he quotes have reference to the mortality that follows excision. Thus, he gives Sach's table of 144 excisions of the knee, with 25

deaths (of which 13 were due to tuberculosis); Mr. Croft's 45 excisions of the hip with 18 deaths, 6 caused by tuberculosis; and Grosch's analysis of 120 excisions of the knee, with a mortality of 36.7 per cent, more than half which depended on tuberculosis. The mortality here is undoubtedly so high that Mr. Barker's desire to reduce it is both natural and praiseworthy. In Mr. Wright's cases, again, the mortality can not be estimated at less than 20 per cent. On the other hand, in cases of suppuration treated without operation, the mortality, he is confident, is not more than half this amount—that is, not more than 10 per cent. His impression is that it is less than this.

As to the ultimate condition of the limb, our information respecting the results of excision is limited. But, if we take Mr. Wright's table, we find that in less than 20 per cent of his cases had the wound healed, while in 37 suppurating cases, treated without operation, and taken without selection, there were only four in which sinuses were still discharging; and in 65 per cent the patients walked well and firmly, and without material lameness, on the limb. As to shortening, the average amount in 30 of Mr. Wright's cases was one inch and a half; in 35 cases treated without operation the average amount was one inch.

The treatment recommended is that of prolonged rest in the horizontal position combined with weight extension of the affected limb. This method, although of course it involves some important details, is in principle so simple and so well known that it is needless to describe it; but the method of dealing with suppuration claims more particular notice. All abscesses have been opened as soon as they were detected. An incision from an inch to an inch and a half in length is made, matter is evacuated by gentle pressure, and a small drainage-tube, just long enough to enter the cavity, is used for two or three days. The dressing has consisted of carbolic gauze, next the wound, and this has been covered superficially with alembroth wool. The dressing is changed according to the case. In many instances the wound closes in a fortnight or three weeks, sometimes even sooner; in others it becomes a sinus, which discharges for a month or six weeks, and then heals; in others, again, suppuration remains free for several weeks, or even longer, and further openings have to be made; but at length, in a large majority of cases, the wound heals, and no further suppuration, except in a very few instances, takes place.

**UNSUSPECTED LEAD POISONING.**—Dr. Lermuseau has brought before the Liège Medical Society some instances showing that a good many cases of colic, the origin of which is unsuspected, are in reality nothing but cases of lead poisoning. A large number of them are due to the practice of pumping up beer in public houses through leaden pipes, or at least through pipes which contain a considerable proportion of lead. Publicans and others frequently drink this beer early in the morning on an empty stomach, and this habit is a most fruitful source of lead colic. Of course in many cases there is a blue line to be found on the gums, but sometimes this is absent, and then the diagnosis is very difficult. Occasionally the so called method of Cicconardi may be useful in clearing up the diagnosis. It has been employed in Professor Rommelaer's wards, and consists in painting the surface of the skin covering the thorax with a six-per-cent solution of sulphite of soda. If lead is present in the tissues a dark discoloration, caused by the formation of the sulphide, soon makes its appearance. Dr. Lermuseau complains of the apathy and incredulity of publicans, even after their attention has been called to the danger of using leaden pipes for their beer—a danger from which the publican is usually the very first to suffer. It is urged that a stringent law ought to be passed entirely forbidding the use of leaden pipes for beer pumps. Dr. Lermuseau suggests the substitution of glass or hard rubber pipes; but these substances are less convenient because they can not be bent in all directions in the way that lead can. It would appear that, according to a law made in 1790, the communal administrations have all along had ample power to deal with cases of this kind, if they would only exercise it. Something more stringent is evidently necessary, and Dr. Lermuseau urges upon his *confrères* to bring all the pressure possible to bear upon members of the two Houses of Parliament in order to get some more satisfactory legislation on the subject.—*London Lancet*.

**HOW TUBERCULOSIS IS COMMUNICATED.**—Drs. T. M. Prudden, H. M. Biggs, and H. P. Loomis, the pathologists to the Board of Health of New York City, have formulated the following brief and comprehensive statement regarding the contagiousness of tuberculosis in man, and its influence. The disease is the same in nature in animals and in man, and has the same cause. It has been proven beyond a doubt that a living germ, called the tubercle bacillus, is the cause and the only cause of tuberculosis. Tuberculosis may affect any organ of the body, but most frequently first

involves the lungs. When the living germs find their way into the body they multiply there, if favorable conditions for their growth exist, and produce small new growths or nodules (tubercles) which tend to soften. The discharges from these softened tubercles, containing the living germs, are thrown off from the living body. In pulmonary tuberculosis these discharges constitute, in part, the expectoration. It has been abundantly established that the disease may be transmitted by meat or milk from tubercular animals. Among stall-fed dairy cows, twenty or thirty per cent are sometimes found to be affected with the disease, and the milk from such animals may contain the living germs, and is capable of producing the disease. Tubercular animals are also frequently killed for food; their flesh sometimes contains the germs, and if not thoroughly cooked is capable of transmitting the disease. Boiling the milk or thoroughly cooking the meat destroys the germs. As a rule, however, the disease is acquired through its communication from man to man. Tuberculosis is commonly produced in the lungs by breathing air in which the living germs are suspended as dust. The material which is coughed up by persons suffering from consumption contains these germs, and lodging in places where it afterward dries, as on streets, floors, carpets, etc., it is very apt to become pulverized and float in the air as dust. It then follows, from what has been said, that tuberculosis is a distinctly preventable disease. It is a well-known fact that some persons are particularly liable to tuberculosis, and this liability can be transmitted from parents to children. The frequent occurrence of several cases of pulmonary tuberculosis in a family is then to be explained, not on the supposition that the disease itself has been inherited, but that it has been produced after birth by transmission directly from some affected individual. If, then, tuberculosis is not inherited, the question of prevention resolves itself, principally, into the avoidance of tubercular meat and milk, and the destruction of the discharges, especially the sputum, of tubercular individuals.

**EFFECTS OF PROLONGED CHLOROFORM ANESTHESIA.**—Some observations made about two years ago by Dr. Ungar pointed to fatty degeneration of the heart and liver as the cause of death after repeated prolonged administration of chloroform. Further experiments on dogs have recently been made by Dr. Strassman, which appear to confirm this view. Dr. Strassman found that the first organ to be affected was the liver, then the heart, and after that other viscera. The nature of the morbid

change was not a fatty degeneration, but fatty infiltration. The actual cause of death in fatal cases appeared to be the cardiac affection, as in all such a very marked degree of change was found in the heart. In non-fatal cases the morbid change was found to have disappeared in a few weeks' time. When morphia was given previously to the chloroform, less of the latter was required, and consequently the changes produced were not so considerable as when the ordinary amount was given. Animals suffering from hunger, loss of blood, etc., were especially predisposed to the morbid changes due to chloroform.—*London Lancet*.

**INDUCTION OF PREMATURE LABOR BY HEGAR'S DILATORS OF SPECIALLY LARGE SIZE.**—Dr. Arthur Lewers, Assistant Obstetric Physician to the London Hospital, writes, in the *London Lancet*: The method most in favor at present for the induction of premature labor is the passing of a bougie several inches into the uterus, between the membranes and the uterine wall, and leaving it there till labor pains come on. Hot vaginal douches are usually given as an adjuvant from time to time while the bougie is in place. Now, it not rarely happens that there is a considerable interval between the time of insertion of the bougie and the setting-in of labor. This interval has been as much as a week in some cases that have come under my observation, both in my own practice and in that of others. It can not be foretold with any certainty how long it will be before labor will come on after the insertion of the bougie. The practical inconveniences of this to every body concerned are, of course, obvious. Another plan occasionally employed is to dilate the cervix with tents. Here there is the risk of septicemia, and this is especially so if more than one set of tents has to be used.

Looking at the satisfactory results of dilating the cervix with Hegar's dilators in gynecological practice, I thought a similar method was worth trying for dilating the cervix in order to induce labor. The ordinary dilators used in gynecology not being of sufficient size for this purpose, I had made a larger series running up to No. 40, which is  $1\frac{3}{4}$  inches in diameter. It will be remembered that the ordinary series stops at No. 26. The details of the method are as follows:

The patient is given a copious vaginal douche of hot iodine-water; she then lies in the ordinary obstetric position, and the os uteri is brought into view with Sims' speculum. Hegar's dilators are then passed

one after the other till a size is reached which seems to be the largest that will for the time being pass into the cervix. The dilators lie ready for use in a porcelain tray covered with 1 in 40 carbolic lotion, and as each one is wanted it is dipped in terebene oil (1 in 5). In a few minutes the dilator will be found to be fitting less tightly, and then it may be withdrawn and the next size introduced. As the larger sizes are reached, more time should, if necessary, be allowed between the introduction of the dilators; but it may happen, as in my first case, that the whole series as far as No. 34 (which was then the largest I had) may be passed one after the other without any difficulty being met with. During the process the vagina is from time to time irrigated with 1 in 40 carbolic lotion. When the largest bougie of the series has been passed, it is left in the cervix, the lower end of the bougie resting against the posterior vaginal wall. The presence of the dilator, *plus* the degree of dilatation already present, may be sufficient to start strong pains, and when this is so, the dilator is withdrawn and labor allowed to proceed in the usual way. If only slight pains, or no pains, result—say, four hours after the insertion of the largest size—the membranes may be ruptured. Considering that the os is dilated to the size of a circle  $1\frac{3}{4}$  inches in diameter, this proceeding is not open to the objections that apply to rupturing the membranes in the first instance, when the os is undilated.

E. W., aged forty-six, was admitted to hospital January 9, 1889, for the purpose of having labor induced. She had had seven children; all her labors were difficult, and in her last confinement the child had to be destroyed and delivered with instruments. She reckoned that she would be at her full time on February 9th. On January 10th, at 4 P. M., the cervix was dilated with Hegar's dilators up to No. 32 without difficulty; this size was left in the cervix till 10 P. M., when No. 34, the largest we then had, was introduced. Copious hot douches were given frequently; and on the 12th, at 1 P. M., the largest-sized Barnes' bag was substituted for the Hegar's dilator by Dr. Lys, the resident accoucheur. On the 13th, at 2 A. M., as no pains had come on, the Barnes' bag was removed, and at 2:30 P. M. the membranes were artificially ruptured. Shortly afterward labor pains came on, and the child, a girl, was born naturally at 8:45 P. M. It weighed five pounds and one ounce, and was twenty inches long. Both mother and child subsequently did well.

E. C., aged twenty-one, admitted to hospital April 4, 1889, for the purpose of having labor induced. She was last poorly some time in September, 1888. She was married on October 7th, and had "seen nothing" since. She has never been able to walk since she was a little child. When about two years of age she had strumous disease of both knee-joints, and some years afterward was in the hospital with hip disease. At the present time both knee-joints and both hip joints are fixed in a position of extreme flexion. The left knee and hip-joints are less absolutely fixed than the right. The whole right lower extremity is smaller than the left. There is a marked dorsal kyphosis and lumbar lordosis. The patient is very active and gets about on her hands and knees, though for obvious reasons she does not care to go out into the streets. When raising herself to her full height the top of her head is only two feet ten inches from the ground. To estimate what her height would be if her knee-joints and hip-joints were not flexed, the trunk, thigh, and leg were measured separately, and these measurements added together; this gave 4 feet 10½ inches as her height. The measurements of the pelvis were as follows: between the anterior superior iliac spines, 9¼ inches; maximum measurement between the iliac crests, 9½ inches; external conjugate, 6½ inches (or, taken a spine lower, 6 inches). On April 11th a careful examination of the pelvis was made under ether, the whole hand being passed into the vagina. The diagonal conjugate was 3½ inches. The left hand, with the proximal phalangeal joints of the fingers flexed, was passed up so as to occupy the true conjugate. The points corresponding to the true conjugate were the proximal phalangeal joint of the little finger (lying against the sacral promontory) and the metacarpal phalangeal joint of the index finger (lying against the pubes). This measurement was between 2¾ inches and 3¼ inches. An ordinary watch-spring ring pessary was also used to estimate the conjugate. One 3¾ inches in diameter was too large to fit into the conjugate; one 3 inches in diameter fitted exactly without being pressed out of shape. Owing to the marked lumbar lordosis, it seemed likely that there might be some obstruction higher than the anatomical conjugate of the brim. On May 13th I judged the patient to be thirty-two weeks pregnant. [Dr. Lewers reports three cases in which he used Hegar's dilators with satisfactory results. We have, however, space for an abstract of one where labor was in-

duced at thirty-second week for deformed pelvis.—Eds.] Hot douches of iodine water were given during the morning, and at 2.30 p. m. the cervix was dilated with Hegar's dilators. No. 9 was the first size used, and ultimately, in less than two hours the whole series up to No. 40 had been passed; this was left in the cervix. The patient was seen again about 9 p. m. She had then been having pains for about an hour. The dilator was then removed, and the membranes were ruptured. The child, a girl, was born alive about an hour after midnight, the forceps being applied.

DISPOSAL OF THE SPUTA IN PHTHISIS.—On no account should patients expectorate on to floors, carpets, and, above all, into handkerchiefs. It is indeed from these last that the greatest danger is to be apprehended. It should be made an invariable habit by day, and, as far as practical, even at night, to expectorate into spittoons. These receptacles should be always partially filled with water so as to avoid the drying of the sputa, and they should be emptied and thoroughly cleansed daily by scalding with boiling water. It is not necessary that the water should contain a disinfectant, but, if any be used, it should be one which would be really effective and free from all disagreeable odor, such as that possessed by carbolic acid. Perhaps the best germicide which can be employed is a strong solution of perchloride of mercury; this should be freely added to the water in the spittoon each morning before use. The use of cloths (as is the common practice) to wipe out these receptacles should be strictly prohibited, as these cloths might, like the handkerchiefs, become a source of danger.

The question now arises, in what way should the contents of these spittoons be disposed of? Pouring them into water-closets, whence they would be conveyed into cesspits or sewers, might possibly in certain cases be attended with danger, as still more probably would the throwing them on to the soil. The safest and surest plan is the complete destruction of the sputa, and this object may be accomplished in the following manner. A covered vessel, preferably of glass, of suitable size and provided with a rod, should be partially filled with a strong solution of perchloride of mercury, and into this vessel the contents of the spittoons should be daily emptied, until it becomes necessary to dispose of the accumulated but now harmless sputa, which may then safely be done by means of the closet or the soil,

The use of a stirrer is necessary in order to break up the sputa and allow of the effective action of the germicide. In very advanced cases, and under some circumstances, it may not be possible to do away altogether with the use of pocket handkerchiefs—unless, indeed, some substitute of little or no value (such as a specially prepared paper) were devised in place of them, so as to allow of its being destroyed as soon as it has been used.

Next, we may consider how the linen worn by phthisical patients should be dealt with. It should be kept entirely apart, and on no account mixed with the linen of other people; and even when made into a separate bundle it should not be sent to an ordinary laundry to be washed, as in the latter case it would be sure to become mixed with the other linen. The infected linen should be washed, with certain precautions, either at home or in a special laundry. The handkerchief—the use of which should as far as possible be dispensed with—should never be allowed to become dry, but should be at once wetted, even before being conveyed to the laundry, and no handkerchief should be in use longer than a day.

Then the rooms, particularly the bedrooms occupied by consumptive patients, require special attention. Carpets, curtains, rugs, etc., should be dispensed with as far as practicable, the sheets and night-clothing frequently changed, and the rooms themselves thoroughly purified, the floors and walls being well and frequently cleaned and dusted. In case of a death from phthisis, the bedroom should be treated in very much the same manner as in the case a contagious malady.—*Arthur Hill Hassall, M. D., London Lancet.*

**ANTISEPTIC PRECAUTIONS IN BERLIN.**—The plan adopted by Prof. Bardeleben, of Berlin, at the Charity Hospital there for securing asepsis is thus described by the foreign correspondent of the Medical and Surgical Journal:

Every patient who is to be operated upon has, immediately before the operation, a full bath and a thorough cleansing with soap and brush. After the induction of anesthesia the part to be operated upon is shaved, cleansed again with warm water and soap, dried with sterilized towels, and washed first with alcohol and then with a one-half-per-cent solution of corrosive sublimate. If the skin is very fat ether is also used together with alcohol. Bardeleben exercises particular care regarding the antiseptic cleansing of the hands, as he has always viewed the surgeon's hand as one of

the principal carriers of infection. In addition, the entire neighborhood of the field of operation is treated with a one-half-per-cent solution of corrosive sublimate and dried with previously sterilized towels. Even the forearms of the patient are cleansed antiseptically to prevent the touching of an impure portion of the body if the pulse should be felt. The surgeons themselves never carry their coats into the wards, but appear in the operating rooms with white linen gowns reaching almost down to the ankle, and opening behind. To complete their resemblance to butchers, they carry on their left side what, from a distance, might be taken for a knife with a black leather sheath, but is in reality a harmless stethoscope. Every forenoon there is a general disinfection of the surgeons' and nurses' coats, of all towels, bed-clothes, brushes, and dressing materials. To effect this sterilization, the apparatus devised by Henneberg and Rietschel, and described by Es-march, is used. The articles mentioned are exposed for thirty minutes to the action of steam at the temperature of 212°. The brushes are then placed in a well closed glass vessel, filled with a one-per-cent solution of corrosive sublimate. As can be expected, special care is bestowed upon all instruments used in the surgical wards of the Charité. If possible, all instruments are constructed of a single piece, to facilitate their cleaning. They are kept in a closed cupboard on glass shelves, and are immersed one-quarter hour before the operation into a three-per-cent solution of carbolic acid. After use the instruments are cleaned with soap and boiling water. Catgut is kept in a five-per-cent alcoholic solution of corrosive sublimate, the solution being removed several times, until it becomes clear. The silk used for sutures is sterilized in a small steam apparatus, rolled up, exposed again to a steam-bath, dried under a glass cover by the action of sulphuric acid, and then placed in a closed box filled with camphor.

Wounds are left open as short a time as possible. They are closed with sterilized gauze immersed in a weak solution of corrosive sublimate. During an operation every bleeding vessel—no matter whether artery or vein, large, or small—is tied with catgut. The wound is dried with sterilized gauze and then treated with a warmed one-half-per-cent solution of corrosive sublimate.

**CALCIUM CHLORIDE IN GLANDULAR AFFECTIONS OF THE NECK.**—Calcium chloride is an agent which was held in the highest esteem by the earlier practitioners of medicine, but is hardly recognized by therapeutic authors of

the present day. Dr. S. Coghill, of the Royal National Hospital for Consumptives at Ventnor, in a communication to the Practitioner, states that he has "again and again seen chronically indurated and enlarged glands which absolutely amounted to deformity, and which had resisted all previous treatment, yield, even in adults, to the administration of this salt. In children and young persons, when the sleep becomes restless, the breath fetid, the tongue foul and coated, the tonsils enlarged, I know of no remedy approaching it in value. The colliquative diarrhea, which so often accompanied this condition, and above all, that obstinate dysentery which is seen with hypertrophy of the mesenteric glands, yield to the solution of the chloride of calcium like a charm."

Dr. J. Mays writes, in the the Archives of Pediatrics: "I have used this agent for a number of years, both in private and public practice, and can fully indorse the strong views expressed by Dr. Coghill, especially so far as scrofulous affections of the neck are concerned. . . . Here the chloride of calcium acts admirably. It reduces the enlargement, promotes nutrition, and is generally more efficacious than any thing I have ever prescribed. Its resolvent power is equally marked in the glandular swellings of adults, although here it requires a longer time, and its action is facilitated by the simultaneous application of iodine."

This agent must not be mistaken for the chloride of lime—the ordinary disinfecting powder—the composition of which is entirely different. By prescribing the granular calcium chloride this possible error will be avoided. The dose is from two to four grains for children, and from ten to twenty grains for adults. It can be given in milk or water, but the best vehicle for it is the syrup of sarsaparilla.—*N. Y. Med. Times.*

**BIBORATE OF SODA IN EPILEPSY.**—Dr. J. D. Munson, Medical Superintendent of the Northern Michigan Asylum, writes in his last report: The baborate of soda has been found quite equal to the bromides in controlling the seizures. In some cases it has been found superior. It is prompt in its action, and does not affect badly the general condition, and is usually well borne after the first few doses.

"Biborate of soda tends to constrict the peripheral blood-vessels in a remarkable manner, and to this action is doubtless due its beneficial action in epilepsy. In epileptics with high arterial tension borax is sometimes harmful, while in those with low arterial tension, but strong heart action, it is most apt

to be useful. He mentions the following drawbacks to its use. "Given regularly in moderate doses it is apt to affect the nutrition of scalp, the hair becoming rough and brittle, and in one or two cases alopecia has followed. A troublesome psoriasis is occasionally induced, which, according to our experience, has not yielded readily to treatment, nor has the administration of Fowler's solution with it always prevented its appearance. In one case a suppurative inflammation of the middle ear was always induced by the use of the biborate."

He gives the drug always after meals—advises that it be alternated with the bromides and not given for long periods continuously.

**SOME HAIR RECIPES.**—Lassar, of Berlin, in 1882 published, in connection with our fellow-countryman, Bishop, an account of some experiments tending to show that alopecia prematura was contagious, and could be cured by antiparasitics. In this article (*Therap. Monatsh.*, 1888, No. 12) he still insists upon the contagiousness of ordinary baldness, and its spread through the agency of barbers and the employment by several persons of one comb in common. Even though as yet no definite parasite has been found in alopecia, Lassar believes that there is one, and that it will be found in time. He does not believe that alopecia areata is a neurosis, though he allows the possibility of it in a few cases, but does believe that most cases are from contagion. In the past few years he has met with many hundreds (?) of cases of alopecia areata, many of which have been in relatives, patrons of the same barber shop, school mates, or possessors of dogs or cats having similar bald spots. In the belief of the parasitic origin of alopecia, our author has treated more than a thousand cases by means of an antiparasitic plan of treatment, and with marked success. His method is the following: For six to eight weeks the hair is washed with a soap rich in tar (Berger's), the suds being rubbed well in for ten minutes each day. Then the suds are washed out with warm, followed by cold water, the scalp and hair dried, and the face anointed with solution hydrarg. bichlor. (one third of one-per-cent strength), glycerine, and cologne water, equal parts; then rubbed dry with absolute alcohol containing one-half per cent of naphthal, and then anointed with salicylic acid, 5 ss.; tincture of benzoin, gr. xlv; neat's-foot oil, 50j. M. After six to eight weeks the process is to be less often repeated. In obstinate cases the sublimate solution should be used many times a day. Or this salve may be used: carbonic acid, 15 grains, sublimed sulphur, 60 grains; benzoin

neck fat to ʒij. M. Another good stimulant is oil of turpentine, either with equal parts of an indifferent oil or with dilute alcohol. Another one is, pilocarpine hydrochloride, 30 grains; vaseline, 5 drams; lanoline, 2 ounces; oil of lavender, 25 drops. M. Tar is good; and as a final formula we have: pilocarpin. hydrochlor., 30 grains; quinin. hydrochlor., 1 dram; sulph. precipitat.,  $2\frac{1}{2}$  drams; balsam. peruv., 5 drams; medul. bovin., ad ʒij. M. *New York Medical Journal.*

**LONGEVITY.**—At a banquet recently given to an old and leading lawyer in Boston, the question was asked of the honored guest, what he regarded as the secret of his longevity. He replied, "Contentment of mind." He had found the truth of the saying that it was worry more than work that killed people.

About the same time another banquet was given to another lawyer in New York, at which our famous orator, Mr. Depew, made a speech in which he set forth his views of the secret of long life.

"Activity," said Mr. Depew, "is the great secret of longevity." His idea is that human life must be a wide awake, running stream of mental and industrial activity in order to insure its healthful and lengthened existence.

Again, Mr. Gladstone, in some respects the foremost man of the age, was asked what he looked upon as the cause of his longevity? The old man eloquently replied, "Active labor, with seasons of rest." Putting these several cases together, we have a large part, though not the whole story told of the secret of longevity. Temperance or moderation in all things must enter in as a daily principle of living. The appetites and passions must be kept under steady control, and if there is a tendency in any one appetite or passion to gain the mastery, there is the place for watching and putting on the brakes, lest vitality be sacrificed to indulgence. Contentment of mind, the first-mentioned cause of longevity, is not attained without self-discipline and much thought. Just and sober views of life are necessary, true philosophic views, freedom from inordinate selfish ambitions, a benevolent impulse as the controlling motive of action, and a good conscience; these are all powerful promoters of contentment of mind. "The proud and covetous can never rest." Have a good conscience and thou shalt ever have joy. "He enjoyeth great tranquility of heart, that careth neither for the praise nor dispraise of men. At the

same time activity in some useful calling is greatly helpful to contentment, and so to health and longevity. People as they grow old may lay off a part of their accustomed burdens rather than take on new ones, yet regular employment both of body and mind, with proper seasons of rest, will be found conducive to a happy lengthening of days. *American Pharmacist.*

**LACTOSE AS A DIURETIC.**—Professor Germain Sée declares, after abundant clinical experiment, that lactose is the most powerful and at the same time the most inoffensive diuretic that we have, one hundred grams of sugar of milk producing a diuresis that we are not certain to get with five quarts of milk. The polyuria resulting from the ingestion of the above-named quantity of milk-sugar is greater than that from any other form of medication. It produces very rapidly two liters and a half of urine, and this goes on to three and four quarts on the third day. Then it becomes stationary for a few days, and gradually falls again to two quarts and a half. During this time any edema or dropsy that may exist disappears, while, the blood being dehydrated, there is no longer the same quantity of urine eliminated, but after a few days of repose the same effect can be produced by the same dose of lactose.

The diuretic action of lactose may be prevented by lesions of the kidneys and by diarrhea; profuse sweating also may diminish its power, but it will certainly be shown at a later period. The sugar of milk is well borne, and should be prescribed for eight or ten days at a time, allowing a few days to elapse between each period. Dr. Germain Sée gives one hundred grams of lactose to two quarts of water, and this can be made more agreeable by the addition of a small quantity of brandy or mint-water. All other drinks are forbidden. Even soup, if given, is measured, so that the quantity of all liquids taken will be known and their diuretic effect observed.

Dr. Sée is studying another group of diuretics, which he calls the "renal diuretics." They consist of caffeine and theobromine. He also insists again, that when dyspnea exists iodide of potassium is the remedy to add to diuretics in all heart cases. He finds it is useless to change the iodide of potassium for iodide of sodium, under the mistaken notion that the first is toxic. Indeed, Dr. Sée believes that iodide of potassium is the best medicine we have for the heart and the circulation, and that it only

lacks a diuretic effect, which he finds in lactose.

M. Dujardin-Beaumetz also has tried lactose in his hospital service and had good results, but he was led to try also glucose. He dissolved the grape-sugar in milk and found that it also had a diuretic effect. He found, in fact, that all the sugars had a diuretic action, if the kidneys were in a state favoring their action, but, fearing glycosuria, he advises the use of lactose only. — *New York Medical Journal*.

**INDUCTION OF PREMATURE LABOR.**—Dr. Chenevière, in the *Revue médicale de la Suisse Romande*, gives an account of a simple method which he has employed for inducing premature labor. The cervix is brought into view with a speculum, and about twenty small iodoform tampons are passed through the os uteri by means of a thick sound. The plug reaches rather above the internal os. A larger plug is then placed against the vaginal portion to keep the cervical plug in position. Three cases are given in which the method was adopted. In the first, pains came on in two hours, and the labor was terminated in fourteen hours; in the others, more than one plugging of the cervix was necessary, labor taking place on the following day. In one case some of the tampons were only passed several hours after the expulsion of the fetus and placenta; and the author therefore thinks it well to have the tampons counted to avoid the possibility of any being left behind. — *British Med. Jour.*

**CARDIAC STIMULANTS.**—It is of the utmost importance in the treatment of disease to maintain the action of the heart and to stimulate it when it is flagging. Among cardiac stimulants beef tea still maintains a foremost position. We have drugs which increase the power of the heart, and which are most useful in their place—digitalis, strophanthus, convallaria, adonis vernalis, and erythrophleum, and the whole class of drugs usually known as cardiac poisons. Unfortunately these drugs do not always give us the result we desire, and at present we are often unable to say why they fail. We do not know their chemical constitution, and consequently we can not modify it or produce at will drugs having a similar but not identical action, as we can, to a certain extent, in the case of antipyretics and analgesics. Xanthine, one of the constituents of beef tea, has a very powerful action on voluntary muscle fiber, but its effect on the heart requires to be more carefully made out.

Methyl xanthine, or caffeine, is now recognized as an important cardiac tonic. Like xanthine, it tends to increase the contraction on muscular fiber, both voluntary and involuntary, and when its action is pushed far enough it produces an extraordinary state of muscular rigor. In consequence of this, voluntary muscles dipped into a solution of it frequently contract to the utmost extent of which they are capable, and when applied to the frog's heart it causes the beats to become slower and the heart more and more contracted, until it ceases to beat in systole. In this action it agrees with the other cardiac tonics, like digitalis, although it usually causes firm contraction of the frog's muscles; yet sometimes it causes none at all, and may even cause elongation. — *T. Lauder Brunton M. D., London Lancet*.

**SUPRAPUBIC CYSTOTOMY.**—H. E. Herting, M. R. C. S. (*British Medical Journal*), reports the results of thirty-one cases of suprapubic cystotomy, comprising all the operations of this nature performed by Sir Henry Thompson, and extending over the period from 1865 to the present date of this number. Two were performed by the old method as practiced before the adoption of Garson's modification, both of which resulted fatally. The twenty-nine cases of the new operation include eleven for tumor of the bladder, only one of which was fatal, death resulting from pyemia; and eighteen for calculus, with three deaths, showing on the whole a considerable degree of success, especially when we note that "all of these cases represent the most advanced and the most complicated examples of disease."

In the performance of the operation the chief points to be noted are a full distension of the rectum associated with a moderate distension of the bladder, a small abdominal incision thus avoiding the use of a ligature, and an opening into the bladder sufficient to admit one finger only, by this means rendering stitching unnecessary.

**DISEASES OF THE PROSTATE.**—The treatment of chronic prostatitis as recommended by Berkeley Hill (*British Medical Journal*) is general and local. The non-astringent iron preparations, nux vomica and strychnine as tonics, belladonna if there be incontinence during sleep, and ergotine when there is much enlargement of the organ, with abstinence, constitute the general treatment. Locally he employs the cold sitz bath of a temperature of from 50° to 65° F., taken once or twice daily, at first for one or

two minutes, and gradually prolonging to ten minutes, the cold douche on the perineum, daily enemata of from two to four ounces of cold water, beginning at a temperature of 45° F., and gradually lowering to 35°, and in the later stages of the disease injections of ten minims of a solution of silver nitrate of a strength of 20 to 30 grains to the ounce, which must be repeated at intervals. In prostatitis arising from masturbation or excessive venery, one dram of the fluid extract of *salix nigra*, three times a day, will often check the involuntary emissions, while too speedy ejaculation during copulation may be relieved by the use of the fluid extract of *damiana*.

In the latter stages of the treatment of tuberculous prostatitis antiseptics is the main point to be observed. Dr. Hill recommends for this purpose the cleansing of the bladder by repeated small injections of boric-acid solution, to be followed by an antiseptic solution consisting of two grains to the ounce of sulphate of quinine. A still more powerful antiseptic is an emulsion of iodoform, the formula of which is: iodoform, 2 parts; mucilage, 4 parts; glycerin, 2 parts; water, 20 parts. One or two drams of this will remove all fetid ammoniacal urine and cause a marked improvement in the condition of the patient. If there be much pain experienced while washing out the bladder, an injection of cocaine previously given will overcome this difficulty.

**COPAIBA IN SURGERY.**—In *Medical, Surgical, and Anatomical Cases*, published by Lawrence Heister, in London, 1755, I was struck with the importance he attached to the balsam of copaiba in his dressings, and determined to test the drug in that capacity. It was accordingly applied to an indolent granulating surface, by first saturating charpie with the balsam, and, after squeezing out the superfluous balsam, bandaging the charpie upon the ulcer. The unusually rapid growth of a handsome bed of rosy granulations, ready for the grafting process, was so clearly attributable to its use, that I continued to employ it, and finally adopted it as a regular dressing to granulating surfaces in my hospital wards. It is simple, cheap, quickly prepared, and most satisfactory in its results. Its use has gradually spread to the wards of my colleagues at the hospital, and it is now an accepted dressing, being especially adapted to the flat, pale, granulating surfaces that commonly result from avulsions of the scalp, extensive burns and scalds, also for the cavities after operation for removal of necrosed and carious bone.

It has succeeded in raising healthy granulating surfaces for grafting after other stimulating applications had failed. At the hospital it is applied with cotton-waste instead of charpie. The waste can be easily picked apart and cut into short bits by convalescents. The porous nature of the dressing permits a ready absorption of pus and of its partial disinfection by the copaiba, which imparts a fragrant balsamic substitute for the sourish odor of pus partly decomposed. On the chances that its activity as a dressing depended upon the copaivic acid which it contains, I have also applied that substance with a negative result. *H. A. Beach, Boston Med. and Surg. Jour.*

**CREOLIN INJECTIONS IN DYSENTERY.**—Dr. Sosovski has found large enemata of dilute creolin very useful in dysentery. He employed a one-half-per-cent solution injected into the bowel twice or sometimes three or four times daily, the quantity used for each enema being generally about five pints. The patients did not experience any burning sensations or abnormal pain. The treatment was employed in sixteen cases, not one of which proved fatal, although a considerable number of patients succumbed to the disease during the same epidemic. In two cases the disease was arrested after the second enema, in nine cases the bloody stools ceased on the third day, in two cases on the fifth day, in one on the sixth, and in one on the ninth. The remaining case, though more obstinate, ultimately recovered completely. In addition to these, two children under a year old were treated successfully by means of creolin enemata. Another physician, Dr. Kolokoloff, has used a one-per-cent solution in a number of cases of adults with complete success.

**MATERIAL FOR LIGATURE AND SUTURE.**—Dr. Thomas H. Manley, M.D., of New York, writing on this subject in the *International Journal of Surgery* for August, says:

Nothing yet has been discovered which for all around work will take the place of silk.

It possesses two invaluable qualities, durability and strength, and when thoroughly aseptic will lie unchanged in the tissues for a long time.

In abdominal surgery, in ligating pedicles and old, well-developed adhesions, and in securing the great arteries of the extremities, no material has yet been discovered which will take its place.

Catgut will do very well with small unimportant vessels, when primary union of the flap is looked for, or in making incisions to expose a bone or a growth, but "to do duty" for silk in the major operations it never can.

Catgut as a suture, however, is quite another thing. Here there is a large field for its use; yet, where there is much tension, and only gradual union is expected, it is useless. For mere apposition purposes, owing to its absorbable qualities, it has no equal. Hence, when it is to be used, unless prompt union is expected, it should be always reinforced by a deep silver or silk suture, or else supported by adhesive straps, till union along the seam is fully assured.

With all the advantages, however, which catgut or tendon possesses, it can hardly ever come into general use, even for the place here assigned it. It requires a special set of needles with an expensive needle-holder. The needles are large and clumsy and do a vast amount of mutilation; besides if one is unfamiliar with the needle-holder he can do nothing with it; and without this latter instrument the needle can not be worked.

Another drawback is that these albuminoid materials rapidly deteriorate, requiring fresh supplies, which to the country practitioner is a nuisance.

**CYSTITIS IN WOMEN.**—Dr. Madden, of Dublin, treats severe cystitis in women by dilating the urethra, which permits a continuous outflow of the secretion. This treatment, together with mild washing of the bladder, usually effects a speedy cure. If not, the fundus and neck of the bladder should be wiped with a bit of cotton soaked in carbolized glycerine and passed through the dilated urethra. The use of cocaine will prevent the pain of the operation. *Medical and Surgical Reporter.*

**PERSPIRING FEET.**—In recent numbers of *The News* we have quoted several applications for fetid perspiration of the feet, last among which was a five-per-cent solution of chromic acid, used in the German army, and which has since proved successful in ninety-two per cent of the cases upon which it was tried. *The Gazette des Hôpitaux*, of July 23d, gives two additional formulæ, which are claimed to be the most efficacious in overcoming this stubborn affection. Dr. Bardet gives one formula, which is as follows:

French chalk.....40 parts;  
Subnitrate of bismuth.....45 parts;  
Permanganate of potash...13 parts;  
Salicylate of soda..... 2 parts. M.

This powder should be dusted daily into the stockings. The feet should be washed every morning and evening, and after washing rubbed with alcohol.

The second method of treatment, which is recommended by Dr. Unna, is as follows:

Ichthyol..... 5 parts;  
Turpentine..... 5 parts;  
Zinc ointment.....10 parts. M.

This ointment should be applied after the feet have been bathed in water to which a little vinegar, mustard, or spirits of camphor has been added. During the day they may be dusted with the following:

Powdered mustard..... 1 part;  
French chalk.....30 parts. M.

**HEMATEMESIS**, according to the *Pittsburgh Medical Review*, is quickly relieved by water swallowed as hot as can be borne in quantities of half a tumblerful to a tumblerful. No further hemorrhage occurs, and fragments of clots are vomited—*College and Clinical Record.*

THE best treatment for burns and the indolent ulceration which follows them (Therapeutic Analyst) is the following:

Iodol..... } aa 5j.  
Ichthyol..... }  
Cosmoline .....5j.  
M. Ft. ungt.

*L'Union Med.* recommends the following (College and Clinical Record):

Acid. carbolic.....p. 1;  
Extract conii.....p. 40;  
Iodoformi.....p. 80;  
Unguent rose.....p. 600.  
M. Ft. ungt.

DR. W. M. BEEK writes to the *Medical Record* that in the early stages of quinsy he has found chloral hydrate nearly a specific, three or four grains to the ounce of glycerine being used as a gargle. Its efficiency and *modus operandi* are at once apparent when we consider that it is locally antiseptic, astringent, and sedative.—*Ib.*

DR. B. FRANK HUMPHREYS (*Therapeutic Gazette*) considers that the new antipyretics are usually reliable and potential means for the reduction of high temperature and the mitigation of pain, but that they are, nevertheless, agents capable of producing more or less injury if administered when contra-indicated, or too freely for a considerable length of time. It is an open question, he thinks, whether or not any real benefit results from the use of remedies which merely control symptoms without removing the cause.

In the treatment of mental diseases the American Journal of the Medical Sciences refers as follows to the use of hypnotics, sedatives, and motor depressants: Paraldehyde is the purest and least harmful hypnotic yet introduced, when the insomnia is marked and intractable. Urethan and sulfonal can not compare with it. Opium and chloral have special dangers and disadvantages. A combination of cannabis indica and the bromides is the best and least harmful of the general sedatives. Hyoscin is the best pure motor depressant, but it needs great care.

DR. J. A. POLLARD (Therapeutic Gazette) recommends dram doses of glycerine for the prevention of gastric disorders in convalescence from debilitating diseases, for the vomiting of pregnancy, and for the prevention and relief of the greater number of cases of summer diarrhea of children.

A METHOD OF TREATING PRURITUS AND IRRITABLE SKIN.—I have used, with good results, a cone composed of cocoa butter impregnated with two per cent of cocaine. This is rubbed over the part affected. The warmth of the skin melts off a layer of the cocoa butter, which forms a soothing emollient shield over the irritable patch.

The remedy has been put up in the form of cones, inclosed in boxwood cases with screw-tops, something after the manner of menthol cones. These can be carried about by the patient, ready at any moment for self-application.—*Norman Porritt, British Med. Journal.*

THE TREATMENT OF FRACTURE OF THE PATELLA.—The editor of the Medical News, after reviewing the several methods of treatment in use for fractured patella, thus summarizes his views of the subject:

The old method of immobilization of the joint upon a posterior splint with retention of coaptated fragments by bandages will furnish a large percentage of successful results, and is to be employed in default of special instruments, or of the opportunity to carry out operative methods with the necessary protection; but it requires that the fragments should be left uncovered for frequent examination in order that subsequent separation may be promptly detected and remedied.

Malgaigne's hooks, in any of their modified forms, accomplish their object with much certainty and freedom from risk, but occasionally suppuration occurs.

The various subcutaneous methods hold

out a fair promise of both efficiency and freedom from risk, with the advantage that the patient needs close supervision for only a few days, or until the punctures in the skin shall be healed. He can then be dismissed with a plaster splint, to be worn for a month, with no anxiety lest the adjustment of the fragments should be disturbed.

The operation of opening the joint and wiring the fragments should be used only under exceptional circumstances.

THE DISINFECTION OF THE HANDS.—Pauschinger and Furbringer are of opinion that the thorough scrubbing of the hands with soap and warm water was more important than the use of any particular antiseptic solution. The latter's directions are briefly as follows: Clean the nails, scrub the hands for one minute with soap and warm water, immerse them for one minute in alcohol (ninety per cent), and wash them for another minute in a solution of bichloride of mercury, one to two thousand, or in a solution of carbolic acid, one to thirty.—*New York Medical Journal.*

A COMMITTEE of the British Medical Association reports: (1) That habitual indulgence in alcoholic liquors beyond the most moderate amount has a distinct tendency to shorten life, the average shortening being roughly proportionate to the degree of indulgence. (2) That of men who have passed the age of twenty-five, the strictly temperate, on the average, live at least ten years longer than those who become decidedly intemperate.

TO CLEAN HYPODERMIC SYRINGES.—Syringes whose canals have become obstructed so that a fine wire will not pass are cleaned by holding them for a moment over a flame; the foreign substance is thus quickly destroyed and driven off. If a wire has been rusted into the needle, it should be dipped in oil before holding over the flame. To remove the rust from the interior of the canula, pass oil through the canula, then rinse it out with alcohol.—*Deutsche Med. Wochenschr.*

VOMITING IN PREGNANCY.—I have not failed once for many years, by a single vesication over the fourth and fifth dorsal vertebræ, to put an end at once to the sickness of pregnancy for the whole remaining period of gestation, no matter at what stage I was consulted. The neuralgic toothache and pruritus pudendi of the puerperal condition yielded as readily, and to one application.—*London Lancet.*

**ANTISEPTIC MIDWIFERY.**—In August number of American Journal of Medical Sciences, Dr. Henry J. Garrigues, of New York, makes special reference to the use of corrosive sublimate and creolin in obstetrical practice.

As the result of extended research he is able to cite twenty-two cases in which the use of corrosive sublimate has been attended with fatal results. In the majority of these cases he is confident that a too strong solution was used. He recommends that the solution be made 1-5,000 as yielding the necessary antiseptic action, and less dangerous to the patient.

He speaks, secondly, of creolin as one of the latest antiseptics, and highly recommends it for thorough trial. It is obtained from English coal, and has the color, consistency and smell of coal tar, and up to 12 per cent it forms an emulsion with water.

It is rated as second only to bichloride of mercury in antiseptic value, a three-per-cent solution being fatal to germs in one minute. A three-per-cent solution causes no unpleasant sensation upon the skin, but a five-per-cent emulsion causes a feeling of smarting. Solutions of one half to two per cent are well borne upon mucous surfaces. Applied in this strength to indolent ulcers it cleanses the wounds, stimulates granulation and healing, often when all other substances had failed. It leaves the surface to which it is applied soft and pliable; and a point of special importance in its use lies in the fact that it is nearly if not entirely innocuous. The following are his conclusions as to the use of these two articles:

1. The solution of bichloride of mercury used for vaginal and intra-uterine injections ought not to be stronger than 1-5,000.

2. No more than 1½ quarts should be used.

3. The fluid should be removed from the uterus and the vagina.

4. No injections should be used in normal cases after the birth of the child.

5. Intra-uterine injections should not be given oftener than once or twice in twenty-four hours; vaginal every three hours.

6. The symptoms and signs of absorption should be constantly looked for, and the use of bichloride discontinued at their first appearance.

7. The symptoms and signs of abortion should be carefully looked for, and the use of bichloride discontinued at their first appearance.

8. It is safest to abstain from the mercurial injections altogether until experience shows that the corrosive sublimate gives better results than any other antiseptic.

9. Corrosive sublimate should be used for disinfection of the outer surfaces of the patient, for the hands of doctors and nurses, and for materials brought in contact with the patient.

10. Carbolic acid is perhaps as dangerous an injection as corrosive sublimate.

11. Other less effective germicides may occasionally answer a good purpose.

12. Creolin is an excellent antiseptic; little poisonous, a powerful hemostatic, and makes all surfaces slippery—properties that recommend it especially in obstetrical practice.

**NORWAY**, with about two million inhabitants, has five hundred and eighty-one physicians and only eighty-nine pharmacies. In these there are seventy-six apothecaries, twenty-one provisors, one hundred and nineteen examined pharmacists, twenty-three assistants, and sixty-four apprentices. One physician to three thousand three hundred and sixty-three, and one pharmacy to twenty-one thousand nine hundred and fifty-five persons, is not so great a proportion but that the Norwegian may live and grow fat.

**ACUTE ARTICULAR RHEUMATISM.**—In the treatment of this disease Dr. H. Linderborn thinks that sodium diosalicylate No. 2 is destined to supplant the use of salicylate of soda. "The dithiosalicylic acids, Nos. 1 and 2, are two isomeric bodies, each of which consists of two molecules of salicylic acid linked together by two molecules of sulphur. No. 2 (sodium salt) is a grayish-white powder, very hygroscopic, and easily soluble without residue in water. According to Hüppe, a twenty-per-cent solution kills the anthrax bacilli in forty-five minutes, in which time the ordinary salicylate has no perceptible effect; similarly with other bacteria. Four cases of poly-articular and one of the mono-articular rheumatism were treated, also one of gonitis gonorrhoea complicated with iridochoroiditis; the dose was 0.2 gram (3 grains) morning and evening—oftener in the more severe cases. The slighter cases showed disappearance of joint-swelling, pain, and fever in two days, the more severe cases in six days. One case was a relapse after salicylate treatment, nausea and noises in the ears were complained of, severe sweating occurred only when 0.8 gram (12 grains) were taken *pro die*. The last mentioned of the above cases was from another hospital, and the patient left cured

in ten days. The advantages of this drug over salicylate acid are: stronger action, therefore smaller doses; tolerance by the stomach (the insoluble dithiosalicylic acid is precipitated from the sodium salt in an acid solution), and absence of unpleasant after-effects.—*British Medical Journal*.

A PLEASANT BEVERAGE, and nutritious, is made (Milner Fothergill) with some malt extract and aerated water. Every morning, or second morning, dilute a certain amount of malt extract with an equal quantity of warm water, and beat it to a syrup. Fill a tumbler one third full with the syrup, then fill with aerated water.

DR. EDSON sums up the etiology of typhoid fever in the following words: First, typhoid fever never infects the atmosphere; second, that it never arises *de novo*; and, third, that the causes of the disease, in order of their frequency, are as follows: First, infected water; second, infected milk; third, infected ice; fourth, digital infections; fifth, infected meat.

TO ALLAY THE THIRST OF DIABETES, Dr. Duchesne recommends: Potass. phosphate, 1 dram; aqua, 5 ounces. M. Sig: Two to four drams several times a day.

A NEW TREATMENT OF ACNE.—Startin (Lancet) describes a method he has recently employed with success. It consists in steaming the face by means of a steam atomizer. The process should be kept up for some twenty or thirty minutes, and the face then gently rubbed with a soft towel. Tincture of benzoin may be used in the medicine cup.

SALT IN MILK FOR CHILDREN.—Dr. A. Jacobi (Arch. of Pediatrics), says that the addition of sodium chloride prevents the solid coagulation of milk by either rennet or gastric juice. The cow's milk ought never to be given without table salt, and the latter ought to be added to woman's milk when it behaves like cow's milk in regard to solid curdling and consequent indigestibility. Habitual constipation of children is influenced beneficially, since not only is the food made more digestible, but the alimentary secretions, both serous and glandular, are made more effective by its presence.

PHYSIOLOGICAL ACTION OF ANTIPYRIN.—Dr. Rayner T. Batten and Mr. T. G. Bokenham have investigated the physiological action of antipyrin in the laboratory of Prof. Lauder Brunton, at St. Bartholomew's Hospital, Lon-

don. In a communication to the British Medical Journal they record their observations, and state that the main, if not the sole, action of antipyrin is due, directly or indirectly, to its influence on the nervous system. It appears, according to them, to act on all parts of it—mainly on the spinal cord—but also on the brain and motor nerves. With regard to the special region of the cord affected, they are led to think, from the strong resemblance of the symptoms produced in their experimentation to those of lateral sclerosis, that the action of the drug may be localized in the lateral columns of cord.

OUTBREAK OF PLAGUE IN ARABIA.—It is reported this week that the plague has appeared in the Turkish dependencies on the southwestern coast of Arabia, bordering on the Red Sea, and that vigorous sanitary measures are being taken to check the spread of the epidemic. In modern times this dread disease has more than once broken out in Arabia—for example, in 1853, 1874, and 1879; while from 1878 to 1879 it invaded Astrachan, being, however, comparatively limited in its extent in the latter district. At the instance of the Royal College of Physicians, Drs. Colville and Payne were sent from this country to investigate that outbreak. Practically, it has not occurred in Europe (except in the Balkan peninsula) since the first half of the eighteenth century.—*London Lancet*.

ALLEGED DEATH FROM VACCINATION.—A child recently died at Leeds in consequence of syphilis supposed to have been transmitted by vaccination. An inquest was held, and the evidence was to the effect that lymph from another child was used, and different opinions were expressed as to whether or not the deceased suffered from syphilis as the result of the operation. According to the report, the syphilis manifested itself within eight days of the vaccination, but it is not clear whether this statement refers to the local or constitutional symptoms; if to the latter, it is obvious that the disease was not acquired at the time of the operation.—*London Lancet*.

VALERIANIC ether, in pearls containing five minims, proves a very useful stimulant for anemic women subject to fainting fits and attacks of pain in the region of the solar plexus.

DEATH FROM ETHER.—A patient named Fero died on the operating-table at the Philadelphia City Hospital, from the effects of ether. The operation was for hip-joint disease.—*Canada Lancet*.

# The American Practitioner and News

"NEC TENUI PENNÂ."

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D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } - - - Editors.

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## IS THERE AN ELIXIR OF YOUTH?

"The years that make the stripling wise  
Undo their work again,  
And leave him, blind of heart and eyes,  
The last and least of men."

Brown-Séguard claims that he has discovered an elixir which will restore youth to the aged. (See this journal, August 17th.) He sets forth these claims in detail in a communication he recently made to the Paris Biological Society. Brown-Séguard is so deservedly distinguished as a scientist that his article has been extensively copied and commented upon by the medical press, both in this country and abroad. The practice he introduced has already been put upon trial by scores of physicians in the United States. The newspapers of the day have taken the matter up, and their columns teem with learned, ignorant, humorous, foolish, witty, silly, bright, stupid, solemn, jocular, serious, comic, and clean and filthy disquisitions on the subject. The same or something like it happened in Nero's time, when satyrion was vaunted as a restorer of lost energies, and advertised as capable of making the old young again. Nero himself, though dying at the age of thirty-one, possibly took satyrion, and no doubt many a senile Roman *roué* resorted to its

use. History but repeats itself. The whirligig of time brings back old things anew. Fifteen hundred years after satyrion had its run, diasatyrion, which contained among other ingredients the testicles of the wolf and skunk, figured among the contents of the Cordic Dispensatory, and accomplished no doubt as many wonderful cures as the testicular fluid which has rejuvenated Séguard.

Ponce de Leon heard of the Fountain of Youth, but he never saw it. The septuagenarians of to-day take hope of what they hear of Séguard's elixir, but it is not for them, nor for those who come after them. The old order changeth in many ways, but not in this one; and God fulfills himself in many ways, but this is not one of them. Three-score years and ten bring their inevitable changes. The law is fixed. When in the natural processes of nature desire shall fail, alchemy holds out no hope of restoration. When dead, it is as dead as yesterday—gone never to return. The lean and slippered pantaloons may be replaced with a new garment, but the shriveled limb which it contained can never be made plump again. When "the grinders cease because they are few, and the almond tree flourishes, and the grasshopper becomes a burden," all know that the end of that man is near. No need of science here. The testimony, though mute, needs not to be strengthened by that of either physiologist or physician. The juices of the testicles of neither the wolf nor skunk avail to correct senile atrophy. Atheroma will, alas! continue, whether treated by the seminal fluid of bulls or of rams. A spinal cord once sclerosed by age can not be made new again though the semen of whole herds of goats be administered. And fatty degeneration will per-ist, though the washings from the testes of a million cocks or a million dogs be thrown under the skin. He to whom, by his prescience and masterful skill, is given to "hold commandment on the pulse of life" best knows that, while he may often stay the hand on the dial plate of time, that he sets it back never. In due season the end comes to every living thing. "The

faltering footsteps of decay" grow fainter as they fall; "Lo! all grow old and die."

The vaunted elixir of the French biologist is but another illustration of the infirmities of age, and in this instance of the delusions of the great. If not a mere revival of the animal materia medica of the sixteenth century, it is in no sense cleaner or better. Nor will it prove a boon to other than such physicians as suffer from advertiso-mania, and to the nostrum venders at large. To the rest of mankind the "great discovery" will simply serve to show "what fools we mortals be."

### SHOULD SURGEONS PRACTICE OBSTETRICS?

This question has been agitated somewhat in Louisville recently, and has been found to have at least two sides to it. It is possible, however, to answer it in two words, "That depends." A surgeon pure and simple does not attend parturient women. He does not answer calls to such cases. But it is only in the larger cities that such a class is found. It is the same with the obstetrician—he whose work is confined to the lying-in chamber. Outside these centers specialists in either of the departments named are very rare. In smaller towns, villages, and country, most physicians, except the lesser specialists, are all-round men. All is grist that comes to their mill. They cut for stone, deliver women, they set broken limbs, do laparotomies, rectify uterine displacements, check diarrheas, wait upon smallpox, apply plaster jackets, treat consumption, look after typhoid fever, in a word, undertake any thing that comes handy, and refuse nothing, pay or no pay—to their great credit be it said.

In Louisville there is but one general surgeon who attends on no medical cases whatever. There is not a single physician who practices obstetrics alone. The question therefore might very well have been let rest so far as this place is concerned.

But since the question has been brought up, it may be well to look at it for a moment. Puerperal fever is occasionally en-

countered here. It has never prevailed to any great extent, it is true, but in some part of the town or other there is now and then a case of this disease. It seems to be a well-established fact that puerperal fever is due to a specific poison always introduced from without, always carried to the woman. Unfortunately, we know in but few instances how and by whom it is carried; whether in the dust of the air, or the clothing of the nurse, or by the hand of the physician, or emanations from the walls of the building—if this be a hospital. The detection of the immediate agent which carries it in a given case is but too often an impossible task. The average monthly nurse is clearly at times the cause of the spread of the disease. The physician himself is sometimes the guilty party. Visitors and other friends no doubt occasionally convey the poison from one family to another. Coming then from so many sides, it being possible to reach the woman from so many sources, this most formidable disease must continue to prevail until the use of antiseptics is more generally understood by the public and more uniformly practiced by the profession. When this conjunction occurs puerperal fever, if it does not altogether cease to be, will be far less frequent than at present. As matters now stand, that physician who uses on his own person the most soap and water, who has the cleanest skin, the cleanest hands, the cleanest clothes, and the greatest number of changes of under and other garments, who believes in antiseptics and uses them intelligently, shall be the safest man in the lying-in chamber, while he who is least mindful of these things shall be the most dangerous, whether he be obstetrician, surgeon, or general practitioner. Personal cleanliness and the proper application of the established rules of antisepticism may not prevent the occurrence of puerperal fever in a given case, but they will surely prevent the accoucheur from being the agent of contamination.

From five to eight grains of sulfonal, it is claimed, will stop night-sweats.

## THE LOCAL RECURRENCE OF MAMMARY CANCER.

There is no surgeon who has removed many cancerous breasts without witnessing a number of cases in which the disease recurred. The "dinner-plate" incision, as the elder Gross called his favorite operation in mammary cancer, though supplemented by the thorough cleansing out of the axillary space, so much insisted upon by the younger Gross, was certainly a great advance over the former practice in these cases. But, in spite of all, it often happens that cancerous material is still left at the site of operation. At the Congress of the German Surgical Society Dr. Heidenhain offered some valuable suggestions on this subject, quite in a line with the views of the most advanced surgeons in America. Microscopical examinations of surfaces from which malignant growths had been just removed enabled him to detect bits of cancerous tissue too small to be recognized during the operation, and yet capable of giving rise to subsequent recurrences.\* Hence Dr. Heidenhain urges, and such is our practice, that though the mass is freely movable over the fascia pectoralis, it is nevertheless imperative that the fascia itself, and the superficial layer of the pectoral muscle be completely removed. He further declares that where the cancerous nodule is adherent to the fascia, the entire pectoral muscle, and, if necessary, the periosteum of the ribs also must be excised. Heidenhain considers that his practice entails no more danger than the operations usually practiced, while it adds to the certainty of a permanent cure. Success can not follow operations done for cancer in this situation, unless free access is secured to every part which may be diseased, and every possible point occupied by cancerous deposit completely extirpated. To leave a single enlarged lymphatic, or the least bit of cancerous tissue, is to insure the return of the disease. Much as has been done in the surgery of the breast, much remains.

## ELECTROLYSIS FOR THE RADICAL CURE OF STRICTURE.

It was an unfortunate day for electrolysis and its chief advocate in the treatment of urethral stricture, when Dr. Newman declined to accept the challenge of Drs. Brewer and W. K. Otis, of New York. These gentlemen challenged Dr. Newman to test the value of electrolysis under the supervision of a committee of surgeons selected for the purpose. The experiments were to be conducted in the presence of this committee, and their verdict was to be considered final. The proposition certainly seemed a fair one, yet Dr. Newman refused its terms for what seemed to us very insufficient reasons. He first alleged that he could not have fair play in New York. Next, that dispensary patients were not proper subjects, and finally, that neither of the parties interested should be allowed to furnish the patient.

Medical politics, according to all accounts, are certainly bad enough in the city of New York, but they can not be as bad as Dr. Newman would lead one to believe. For our part, we can see no reason why patients drawn from dispensaries would not serve as well as any other for test experiments. Nor do we appreciate the objection to the contestants themselves selecting the patients, since they were subsequently required to go before and be examined by the committee. Dr. Newman, after declining the challenge offered him, sent a challenge on his own account, proposing that the trial take place in Philadelphia; that the committee consist of one surgeon from Baltimore, one from Philadelphia, and another from New York.

This challenge, we think, was very properly declined by Drs. Brewer and Otis, not only, as they said, "on account of the imputation on the profession an acceptance would imply, but also on account of the practical impossibility of making the constant trips to and fro which such a trial would necessitate." We had hoped better things of electrolysis. We had expected more pluck on the part of Dr. Newman, its chief advocate in urethral stricture.

\* The International Journal of Surgery.

## Notes and Queries.

*Editors American Practitioner and News:*

A POSSIBLE GERM CONVEYER.—Allowing the germ theory to be true, it has occurred to me that doctors themselves may sometimes unwittingly become the means of conveying these germs from one patient to another by the fever thermometer. Every physician now uses the thermometer, placing it under the arm of one patient, in the mouth of another, and in a third, in either the rectum or vagina. Yet it is not every physician who is as careful as he should be as to cleaning the instrument before he returns it to its case. Now, is it not possible that this indispensable little servant may sometimes carry germs of disease from one patient to another?

R. W. FRYMIRE, M. D.

PATESVILLE, KY.

*Editors American Practitioner and News:*

REVISITING the eye and ear hospitals of New York after an absence of more than five years, a number of changes are to be observed. The use of antiseptics is more general than it was. At the Manhattan Eye and Ear Hospital, where cleanliness alone long reigned supreme, nearly every surgeon now applies either Panas' solution, or a saturated solution of boracic acid before operations; the lids and face are first washed with the antiseptic, then the lids are everted and the eye thoroughly douched with it. The bichloride of mercury I have not seen used about the eye for any purpose, but it is still a favorite antiseptic in other regions, for instance, washing out a mastoid sinus.

Hot water alone is used here for cleansing instruments; the water is heated over a little alcohol lamp. The extraction of cataract is done without iridectomy, as a rule, in all the special hospitals of New York. After seeing a number of cases more or less recently operated upon, and a number of operations performed in this way, I am led to believe that the only special danger of this method of extraction is prolapse of the iris; there can be no doubt in my mind that this accident is more prone to occur when no iridectomy is done, and I am confirmed

in this belief by what I have seen in New York. Most surgeons instil a few drops of a one-grain-to-the-ounce solution of sulphate of eserine after simple extraction, to contract the pupil, and thus lessen the risks of iritic protrusion.

As regards the after-treatment of cataract operations, though much has recently been written and said on the subject, it may not be without interest to briefly review the different plans in vogue in New York. In general I am struck with the greater conservatism of eastern surgeons in their after-treatment of operations. In the Ophthalmic and Aural Institute, the New York Eye and Ear Infirmary, and the Manhattan Eye and Ear Hospital, cataract patients are kept in bed for a day or two at least, and have *both* eyes closed with a *bandage*. I have seen no case of cataract extraction here dressed with strips of adhesive plaster, and the universal opinion seems to be that to operate on a case of cataract and to allow the patient to immediately get up and walk about, is to expose him to an unnecessary and unwarrantable danger. Only in the Ophthalmic and Aural Institute did I see patients kept in a dark room after operation. While this course seems at present to be unpopular in America, it is worthy of note that the chief surgeon of the Ophthalmic and Aural Institute is generally conceded to have had the largest experience in this country in the extraction of cataract, and accordingly his opinion must be entitled to more than ordinary respect.

At the Manhattan Hospital I saw a neat, and to me novel application of electric light. A small "bull's-eye" light was brought close to the eye, and the rays from it concentrated in the usual way by a convex lens; it was used in the needling of a thin secondary capsular cataract, and as these thin membranes are sometimes very hard to see, the powerful light came into good service.

Two interesting cases illustrating the use of pilocarpine in ocular surgery I also saw in this hospital: one a case of detachment of the retina in a young woman, and the other a case of chronic glaucoma. The reti-

nal detachment had been treated with several weeks' rest in bed and hypodermic injections of the muriate of pilocarpine; re-attachment had occurred to a large extent, and the sight had greatly improved, being now  $\frac{3}{4}$ °. The surgeon in charge told me that he attributed much of the improvement to the hypodermics of pilocarpine, for with the recumbent position alone he had not obtained such good results. The case of chronic glaucoma was of interest in two respects: a large iridectomy had been done on the eye first attacked without in the least arresting the progress of the disease, which went on to nearly complete blindness; while the other eye, which had been treated with a one grain-to-the-ounce solution of sulphate of eserine locally, and with hypodermic injections of pilocarpine, had not only held its own, but had improved both in visual acuity and in field of vision.

At the New York Ophthalmic and Aural Institute I saw several interesting operations for internal strabismus of high degree; instead of making a tenotomy of one internal rectus, and then immediately or at a later date doing the same operation on the other eye, a tenotomy of the internal and an advancement of the external rectus of the squinting eye were done at the same time; these operations were done with cocaine. The attending surgeon told me that he made a section of the internal rectus of each eye for high degree of strabismus only when the power of convergence in each was excessive; ordinarily he found the tenotomy and advancement to produce more perfect and more permanent results. The method of making the advancement differed somewhat from that usually pursued. After making the section through the conjunctiva and capsule of tenon, and passing the strabismus hook beneath the muscle, temporary sutures were passed through the upper and lower edge of the muscle near its insertion, thus giving the operator perfect command of whatever degree of advancement he wished to make, and allowing as much deliberation and exactness in subsequent steps as was desirable; the tendon having been

cut, three stitches were passed through the episcleral tissue and conjunctiva near the cornea and through the muscle to be advanced, and a certain portion of the muscle in which the temporary sutures had been passed was cut off.

By New York oculists the sulphate of atropia is regarded as the only certain mydriatic for the detection of errors of refraction; homatropia and duboisine are not satisfactory substitutes. At the Manhattan Eye and Ear Hospital I found what has long been known there as Agnew's spray still a favorite and routine application in muco-purulent conjunctivitis; the solution is sprayed upon the everted lids, and seems to be not unpleasant yet efficient. Its formula is:

Sod. bibor.....	}	āā gr. x;
Tannin.....		
Glycerine.....		3i;
Aqua camph.....		q.s. 3i.

S. G. DABNEY.

NEW YORK CITY, AUGUST 11, 1889.

THE FASHIONABLE CONSULTING PHYSICIAN.—Blackwood's Magazine thus sketches the fashionable consulting doctor: "They sit for a great part of each day at the receipt of custom, tossing the sovereigns and shillings into the drawer, where they are decorously put out of sight: pronouncing peremptorily on the destinies of their miserable fellow-creatures, scattering broadcast sentences of death or slow torture, consolation under mitigating conditions, reprieves, or plenary absolution. Custom may lighten the weighty load of their responsibilities, but surely all the same it must sometimes sit heavily on them. For, after all, they are human like the patients, and occasionally they must themselves be out of condition and far from feeling up to the mark. Case after case, and often for the first time, is brought panoramically beneath their observation, and each minute is precious when there are so many to be advised. They are invited at a moment's notice to diagnose the origin and the course of complicated and obscure diseases; they are asked in the way of ultimatum all manner of embarrassing questions as to methods of treatment and probable results.

They must answer the main questions to the best of their ability, and if they do not actually put forward claims to infallibility they are bound professionally to speak with the assurance attaching to their position. As a rule they are sympathetic and strive to soften down unfavorable opinions; but there are desperate cases, and not a few of them in which it would be cruel kindness to conceal the truth. The mother, who brought a daughter she fancied was merely delicate, lifts herself in speechless anguish into the dismal four-wheeler in the conviction that her child is in a hopeless decline. How the sun has been darkened to her during the last long hour or two! and, like Scott standing over the grave of John Ballantyne, she feels it will never again shine on her so brightly as before. The husband, who thought there was nothing serious the matter with his young wife, reads solemn warnings in the ambiguous prognostications of the oracle, and, striving manfully to master his vague apprehensions, knows well that his wedded happiness is at an end."

DR. J. M. KEATING urges, as a preventive of intestinal diseases of children, that the milk obtained each day from the milkman should be boiled, put at once in pint bottles, tightly corked, and then each bottle opened as it is required. This would in a great measure diminish the death-rate from cholera infantum. But if we could supply the families with sterilized milk for their children at as cheap a rate as they can buy milk from the milk-wagon which is standing at the corner of their alley, ladled out to them mixed with the effluvia from an open sewer, poured into a dirty pitcher, and previously diluted with dirty water, certainly kept a whole night before it is brought to the city, and then churned by jogging over the city pavements, we would accomplish a still greater service. He suggests that some of the large city dairies should sterilize, by steaming, a large quantity of their ordinary milk daily, should bottle it in six or eight ounce nursery bottles, and tightly cork and sell these to the mothers in their neighbor-

hood at, say, five cents a quart—which is the usual price that they pay for ordinary skimmed milk—the bottles to be returned when emptied.

TCHENG-KI-TONG, a high military mandarin (*London Medical Record*) has been edifying the world with some remarkable illustrations of the esteem in which native physicians are held in China. One of them having advertised that he had an infallible remedy for curvature of the spine, a hunchback applied to him and asked if he could straighten his back. The doctor undertook to do so, and placed the unfortunate patient on his back on a flat board. He then placed a similar board on his chest and abdomen and loaded it with heavy weights and stones. The result of this novel orthopedic surgery was that the patient was straightened out so effectually that he died on the spot. The quack claimed his fees on the ground that he had kept his promise; the bargain was that he should straighten his patient's back, but nothing had been said about his life! In China it appears the distinction between physicians and surgeons is more sharply defined than with us, and every man is expected to stick to his own branch of the profession. A rich merchant was struck by an arrow which remained fixed in the wound. The principal surgeon of the place was sent for, and after insisting on pocketing his fee in advance, cut off the projecting end of the arrow, leaving the point buried in the patient's body. On being asked to extract it, he said that medical etiquette would not allow him to trespass on a brother practitioner's province; the arrow being inside the body, the case was clearly one for a physician!—*London Medical Recorder*.

THE UTILIZING OF CONDEMNED MURDERERS.—The practical mind of Dr. Frank L. James, of our sprightly monthly contemporary, would utilize the bodies of such criminals, *ante-mortem*, for experimental pathology. This is a good suggestion, and in lieu of the judicial condemnation formulary: "Hanged by the neck until you are dead—dead—dead, and may God have mercy on your soul," we

hope to see the time come when, in pronouncing sentence for capital crime, the judge will solemnly say: "And now you are sentenced, under the laws you have violated, to pay the righteous penalty of your crime. You will, therefore, this day choose the method by which you prefer to die for the benefit of science and that society you have wronged, that, dying, you may serve mankind better than when you lived, and in a part, at least, make propitiation to the world and to God for your great crime, and may God have mercy on your soul." Let the condemned then choose whether by poison, by inoculation of disease, by vivisection or electricity. Give the condemned murderer a chance to make some atonement for his crime before he goes hence.—*Alienist and Neurologist*.

**USE OF THE TESTICLES AS REINVIGORATORS.**—Dr. McCormac, of Mansfield, Oregon, writes as follows to the Medical News:

For over twenty years, to the personal knowledge of the writer, and probably for as many centuries, the Chinese have used the testicles of the sea lion for the purpose of stimulating the organs of generation in man and as a general nerve stimulant.

A great many sea lions are killed in the immediate vicinity of this place, principally for their oil; but the bristles and penis, with testicles, are sold to agents of the Chinese. The first named are used for ornaments, but the last two articles are used by them as medicine. At times as many as one hundred and fifty are seen drying in the sun. When needed, a portion of a testicle is grated into a vessel, and an infusion is made which is administered *pro re nata*.

An attempt at blackmail was recently made against Mr. Malcolm Morris, of London, by a blackmailer named Grandy and a prostitute co-conspirator. They charged Mr. Morris with having, after immoral relations with the female prisoner, broken a promise of marriage made to her; but they were met by Mr. Morris handing them over to the police. Notwithstanding the plea of their lawyer, that they had simply mistaken Mr. Morris for some

other person, they were "sent up" for five years and eighteen months respectively.—*Boston Medical and Surgical Journal*.

**THE LONDON DOCTOR'S WIFE.**—The London physician, however, is but half what he seems; his wife has made for him the better half of his position. She cheers him when he is careworn, defends him if blackmailed, gives lessons in music when he is poor, illustrates his book and revises the text, manages his household and trains his children, brings around him the choicest of his friends, assists him in his correspondence, conducts the family prayers in his absence, returns friendly calls, and finally assumes the title of "lady" with dignity and grace.—*Foreign Correspondent Cincinnati Lancet-Clinic*.

**WORLDLY WISDOM.**—Professor Charfentier, Paris, gives the following advice to physicians, as to the most prudent answer to be given when asked what they think the sex of the child is going to be. "Reply by asking the mother what she would prefer in the child, and then give it as your opinion the opposite is the one to be looked for. In this way, if the sex turns out to be the one you have prognosticated, you will be thought a wonderful man, while if it proves to be the one the mother has wished for, she will be so pleased that she will easily overlook your error.—*Ibid*.

**A SYLLABIC SLIP.**—Dr. Carpenter was noted for the quickness of his wit, and it was a common saying in the town in which he lived that he always had an answer ready when it was required. He was once introduced as "Dr. Carter." Immediately his friend saw his error, and corrected himself. "Never mind," said the doctor, "it's only a slip of the pen"—*Harper's Magazine*.

**A NEW SYMPTOM INDICATIVE OF FETAL DEATH.**—Recently a new proof of the death of the fetus has been brought forward, and it is the presence of peptones in the urine of the mother—that is, she has peptonuria.—*The Clinic Reporter*.

**THE STOLIDITY OF THE CHINESE.**—The Chinaman can write all day, he can work all day, he can stand for a whole day in one position, weaving, hammering gold, or cutting ivory, without once being attacked by nervousness. This peculiarity makes itself apparent in early youth. The Chinaman can bear any kind of bodily exercise. Sport and play are to him unnecessary labor. He can sleep anywhere and in any position—amid thundering machines, deafening noises, the cry of children, or the wrangle of grown people, on the ground, in bed, or on a chair.

A RECENT writer suggests that the eggs of the domestic fowl may be vehicles of transmission of disease germs, so many are the ills to which fowls are heir, as well as the milk of cows. Indeed, come to think of the myriad of known as well as unknown transmitters of bacteria, it may be truly said of them as of old of the pestilence, that they walk in darkness and waste at noonday.

THE study of contagion of to-day is essentially the study of the work of parasites or minute living beings which subsist on other living beings. The contagious fevers of men and animals are now nearly all demonstrated to be the result of propagation in the system of the most minute of these living beings, the bacteria.—*Prof. Law.*

It remained for modern Science to dignify the world; nothing shall be stranger to her touch benign. Even the fungi come into prominence as they come into light. Odd as it may appear, and mysterious, too, they, like some odd and peculiar people, do greatly improve on acquaintance.—*Pop. Sci. Monthly.*

**DIETARY REFORM.**—Doctor: "I see just what's the matter with you. You need something strengthening. Eat a plate of oatmeal boiled, every morning, for breakfast."

Patient: "I do, doctor."

Doctor (equal to the occasion): "Then leave it off."

THE Maine Medical Practice act has been declared invalid through some technicality.

A man in St. Paul,  
Quite feeble and smaull,  
Having lost all his gaul,  
Could not pommel his wife.  
Now, through "Sequard's Elixir,"  
He beats and he kixer,  
And sometimes 'e lixer  
Within an inch of her life.

—*Kansas City Globe.*

DR. LEWIS A. SAYRE has recently been elected an honorary member of the St. Petersburg Medical Society.

### SPECIAL NOTICE.

SIR WILLIAM JENNER has advised the Queen to give up champagne and claret for the present, and to drink whisky and Apollinaris Water.—*Truth, London, July 11, 1889.*

**MENORRHAGIA, LEUCORRHEA.**—Macadam Grog, L. R. C. S., L. R. C. P., Alexandria Avenue, Battersea Park, London, says: F. O. widow, thirty-two years of age, one child, suffered for years, and was frequently under medical treatment, getting little or no relief. When she came under my care, about three months ago, I found her very weak and anemic, complained of pain in left hypogastric region and sympathetic vomiting. She told me that at the menstrual period she nearly flooded, and between the times, only fourteen days, she suffered very much with the whites. I thoroughly examined her and diagnosed: Irritation of the left ovary. menorrhæa, leucorrhæa, prolapsus with atecision of uterus, inflamed meatus urinarius, the effect of this being anemia. Under treatment she improved in general health, but still the menorrhagia and leucorrhæa continued, though I had exhausted the remedies used in such cases. When the Aletris Cordial came under my notice, about six months ago, I put my patient under its treatment, with the result that the menorrhæa and leucorrhæa have ceased, and the slight prolapsus uteri gives no discomfort. I may state that I still keep her under the tonic.

THERE is no other exhibit of the class in the United States section to rival that of Wm. R. Warner & Co. From the globe-advertising Philadelphia merchant comes an exhibit which the native pharmacians can look at with both admiration and wonderment. The display is enough to make any Frenchman curious, and their arrangement such as to be above deprecatory criticism; and those Frenchmen there could not be a people with better taste for the proper and harmonious exhibition of products. A glance through their own magnificent section of pharmacy will verify this. Readers would find superfluous a description in detail of the Messrs. Warner's essentially fine installation covering all their soluble sugar-coated pills, salts, etc. Suffice it to remark that at the Paris Universelle their exhibit is thoroughly representative, comprises all the makers' fabrications, and is decidedly an honor to the concern.—*Pharmaceutical Record.*

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÂ."

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*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.*

## Original Articles.

### DERMATOLOGICAL NOTES—HYPODERMIC INJECTIONS OF INSOLUBLE MERCURIALS.\*

BY I. N. BLOOM, A. B., M. D.

*Dermatologist Louisville City Hospital, Masonic Widows and Orphans' Home, etc.*

The Committee on Dermatology wishes to submit that in this special branch of medicine science has made steady progress during the past year. While there have been no startling discoveries in the etiology or therapy of skin diseases, the marvelous development of former years has been either verified or pretended advances have failed to receive the indorsement of clinical experience. Bacteriological investigations have been applied to skin diseases, and many, the causes of which were formerly obscure, are now known to be of microbial origin. For instance, the weight of testimony goes to show that alopecia areata is of micro-organismic origin. The identity of lupus and tuberculosis and so-called scrofula has been fully established. The failure to cultivate the syphilis bacterium of Lustgarten, and the consequent inability to reproduce the disease by inoculation with the pure culture, has caused the profession to refuse to accept the bacillus theory as proven, in spite of the plausible staining, the differentiation of which Lustgarten has so clearly proven. The development of other and rarer forms of skin trouble has also shown a decided ad-

vance. Diseases which were formerly confused and confusing, owing to difference of nomenclature, are now better understood because of the almost universal adoption of the system of Hebra, and of the greater care and attention which skin diseases are receiving, not only from the specialist, but from the general practitioner. I need only cite the case of lichen ruber, which was formerly regarded as a rare disease, and an incurable one; it is now not only shown to be of at least not infrequent occurrence, but the researches of Unna have proven that it is curable without the administration of systemic remedies.

The disease of most frequent occurrence in dermatological practice is still and will always be eczema. In the treatment of this disease your committee can report but little advance over older methods; it is eminently a curable disease, and the experience of the past year has demonstrated the efficacy of well-known remedies properly applied. As regards therapy of skin diseases in general we will only add the fact, that those remedies of recent use, such as chrysarobin, resorcin, ichthyol, have found their application, and their value has been shown where the indications for their use have been understood. We call attention to a drug but recently introduced, anthrarobin, efficacious in those cases where chrysarobin has been previously considered essential. While less rapid in its effects than the last-named drug, it is yet superior to it in its freedom from dangerous after-effects. The writer has used it in cases of chronic eczema, erythrasma, and tinea circinata, with very satisfactory results. Although used in conjunction with *sapo viridis*, he has seen no signs of dermatitis which so frequently complicates the use

\* Paper read before the Kentucky State Medical Association, July, 1888.

of chrysarobin, and its therapeutical effect was excellent; the staining of the skin, too, is less than when chrysarobin is used. Perhaps the greatest advance which has been made in dermatology, if indeed it can be included under that head, has been that accomplished by the introduction of the treatment of syphilis by the subcutaneous injection of insoluble mercurials, as recommended first by Sarenzio as long ago as 1864. It did not succeed in gaining extended notice until the attention of the profession in Europe was called to its use by Smirnoff, and afterward by extensive experiment in Neisser's clinic, 1886. Neisser's assistants, Kopp and Chotzen, published the tabulated result of 1,523 injections given by them in the clinic. Others, with almost equal chances of observation, soon after gave their experience with this method. Up to this time injections of calomel only had been given; opinions as to its efficacy vary but little. From France, Germany, Austria, and Italy came the almost universal testimony of the prompt effect obtained from its use in both early and late stages of syphilis. The value of the drug from a practical standpoint was, however, called into question, first, because of the pain following its administration hypodermically, second, on account of abscesses which not infrequently resulted; these latter, however, by strictly antiseptic precautions were reduced to a minimum, until now they scarcely average two per cent; experimental success directed attention to the injection of yellow oxide of mercury. This drug was adopted more especially by the French, and found to be as effective as calomel and devoid of most of the unpleasant effects. Although other insoluble mercurials have since then been experimented with, such as tannate of mercury, and the gray oil of Dr. Lang, the contest for supremacy has been between calomel and yellow oxide. America has been strangely conservative on this question, and Dr. F. C. Wilson, of Philadelphia, in an article on this subject, written last month, could find but two American writers, Dr. Morrow and myself, who have investigated the subject at all.

Eighteen months ago (February 19, 1887,) I had the honor of calling attention of the profession to the wonderful claims which men of distinction abroad had laid for this method. I then urged the profession to clinical and experimental researches to prove or disprove these claims. At the same time I resolved to investigate it myself, and in August, 1887, published a short practical article on subcutaneous injection of calomel. This experience I was enabled to enlarge through my connection as Dermatologist with the Louisville City Hospital. But I soon found that while the injection of calomel yielded to no other methods in efficacy, excruciating pain, often lasting from a few hour to several days, and the very frequent occurrence (167 in my practice) of abscesses were serious drawbacks, and led me to abandon it and take up with the yellow oxide. I have used yellow oxide of mercury in ten cases, giving in all eighty-three injections. My method has been as follows: The syringe was carefully disinfected in a five-per-cent solution of carbolic acid; the site of the injection has always been the hollow space situated from a quarter to half an inch behind the trochanter major. This was first carefully cleansed with soap and water, after which either a solution of one to a thousand of bichloride of mercury, or a five-per-cent solution of carbolic acid, completed the asepsis. A Pravaz's syringe (a cubic centimeter, about 15 minims), was injected at one time, and the injections repeated once in 5 to 7 days. The suspension consisted of either water, or gum-arabic, and the yellow oxide in proportions 30-1-3, or what I have since learned to prefer, oil of vaseline 30, yellow oxide 3.

In all the cases which I shall briefly summarize,\* not a single abscess was produced; there were no marked or painful infiltrations except in the case of L. S., where, after two injections, considerable infiltration appeared and great pain was complained of. Stomatitis occurred in this case only, and it is

\* The cases were read from my hospital book. I shall give four cases as types of the rest. They are selected cases, and represent the best, the average, and the worst results obtained.

doubtful if it occurred from the use of the yellow oxide alone. In no case did I fail in obtaining the full therapeutical effect, and in a time which appeared to me much shorter than is usual with the other more favored methods of treatment.

F. S., male, aged twenty-three years, dentist. Has had no other venereal disease. Entered hospital March 31, 1888. Has had chancre about the size of a silver quarter on upper and inner surface of prepuce for three months; inguinal and cervical glandular enlargement; maculo-papular syphilide of a week's duration, covering trunk and upper extremities. Has had no treatment.

March 31st, gave injection (1 c.c.) of yellow oxide-suspension, on the right side at site previously described.

April 1st and 2d: Some pain, enough to keep him awake at night; can not lie on right side; macules growing fainter, but large, flat papules appearing; on forehead five or six of the latter.

April 4th: No pains; sleeps on site of injection; roseola gone; no new papules.

April 7th: Initial lesion in process of absorption; no new papules. Can retract prepuce. No pain at site of injection. Gave second injection on left side.

April 11th: Only pigmentary remains of exanthem; chancre reduced to size of split pea; glandular induration diminished. Had slight pain following last injection, which lasted twenty-four hours. Did not bother him much; feels no pain now.

April 14th: No pain; chancre almost disappeared; pigmentary remains of exanthem. No diarrhea or stomatitis. Injected third syringeful (1 c.c.) on right side.

April 18th: Had less pain than after second injection. In fact scarcely felt it a half hour after. Could lie on either side without difficulty. No infiltration. Chancre healed. No trace of syphilis except indurated glands of groin, and half dozen pigmentary remains of papules on back.

April 21st: Complete disappearance of exanthem; no induration. Pressure over site of injection causes no pain. Bowels regular; no stomatitis. Gave fifth injection as before.

Patient, an intelligent young man, who had observed inunction and other forms of treatment in the ward, says he prefers hypodermic method. Discharged, and told to come as out-patient.

May 5th: Body free; no pain. Sixth injection.

May 12th: Had slight pain, lasting a few hours after last injection. No exanthem. Gave seventh injection.

May 21st: Very little pain from last injection. Complains of sore throat. Mucous patch on arch to left of uvula. Gave eighth injection.

May 27th: No pain worth mentioning after last injection. No induration. Mucous patch on right tonsil size of silver dime. Throat (subjective) symptoms improved.

[The patient did not appear again; but in August, 1888, he reported at my office, stating that he had had no signs of the disease. In June, 1889, I met him on the street, and on questioning him learned that he had been "bothered with sores in the mouth," and was taking "yellow pills" which a friend had advised him to take. Could not return to hospital.]

T. S., white, aged nineteen, peddler. Entered hospital February 16, 1888. Had a sore on glans penis one and a half years ago—small sore, that healed without treatment in five or six weeks. Had previously enjoyed perfect health. One year ago had epididymitis or orchitis (double-sided). Says he never noticed eruption on body until three months ago. *Status præses*, pustular eruption on breast, shoulders, and scalp. Enlarged indurated inguinal glands; cervical glands also enlarged; condylomata acuminata on glans penis and prepuce. Below nipple on right side are superficial cicatrices of previous pustules; also several above umbilicus in median line; above clavicle, on left side, a rupia-like pustule size of silver dime. Similar ulcero-cutaneous syphilide in biceps of left arm and back of shoulder on right side; on scalp six or seven crusts about size of cross section of lead pencil.

February 17, 1888: First hypodermic injection of yellow oxide as in previous case.

February 20th: Complains of severe pain; can not sleep on side where injection was made; pain less daily since injection. No infiltration; pressure over site of injection painful; glandular enlargement noted in groin and neck.

February 24th: Exanthem drying up and crusts falling off—base pale; ulceration on left side of neck toward shoulder filling up. Complains still of pain at site of injection; pain not great. Can not sleep at night on account of headache. Severe, deep pains in left leg and head, pronounced only at night. Gave second injection on left side.

March 1st: Complains of much pain on left side since last injection. Deep-seated pains in head and leg gone; pustules rapidly disappearing; crusts all gone. On head (no local treatment) crusts gone, and flat papules and macules (pale) remain. Gave third injection in right side.

March 5th: Exanthem rapidly disappearing; scabs on head gone; macules barely visible. Has considerable pain at site of last two injections.

March 8th: Pain at site of injections disappearing; also macules and remains of pustules; only pigmentary remains; all outbreak flat and even with the *niveau* of the skin. Gave fourth injection into right side.

March 10th: No pain from last injection. Steady improvement; has had no headache or pain in leg for a week.

March 15th: With one or two slight traces, (pigmentary) exanthem gone. The exceptions are the healed ulcero-cutaneous patch on shoulder and right arm. These show pigmentation only. Scalp entirely free.

B. L., February 8, 1888, female, aged about forty. Phthisical history: has not felt well for a year; does housework; sews. No syphilitic history; no alopecia, sore throat, or recollection of previous exanthem. Present eruption first noticed previous to October. *Status præses*, tubercular syphilide on forehead and left elbow, annular in arrangement. Indurated nodular eruptions on right intra-mammary region covering space about six inches long by four inches wide. Isolated papules here and there on thorax. Large

circular patch about three inches in diameter in left posterior lumbar region. Left buttock covered with well-marked patches made up of individual tubercles. Right buttock involved to slight extent, principally around anus. A few papules below right popliteal space, and a few on right knee around patella; laterally, just above left knee, five small tubercles forming semicircle.

February 8th: Hypodermic injection as in other cases.

February 9th: Complains of pain extending down to knee. Patient hyper-sensitive, unruly, and inclined to be hysterical.

February 11th: Still has pain at site of injection; no infiltration.

February 12th: No pain.

February 15th: Injection (second) on left side.

February 20th: Third injection, on right side.

February 17th: Fourth injection. Decided improvement in patches on forehead and intra-mammary region. Considerable pain from injection. Lay awake and complained all night. Infiltration on right side.

March 5th: Pain at site of injection still considerable, but diminishing. Tubercles on forehead and buttocks almost gone; central part of annular exanthem absorbed and periphery disappearing.

March 10th: Fifth injection. Pain less severe.

March 13th: Great pain and tenderness over site of last injection. Antipyrin grs. x. Some relief. Bromidia 3j, at night.

March 14th: Pain slight.

March 19th: Pain gone; no infiltration; only flat pigmentary remains of tubercles.

March 24th: Patient discharged. No pains at site of injection. Time of treatment, one month, sixteen days. [In the early part of this (1889) year, patient returned with advanced tuberculosis, and died in the spring. She had had no eruption or other form of syphilis in the interim.]

L. S., thirty-seven years old, widow. No history of syphilis. Lacked ordinary intelligence. Poorly nourished. No occupation. Head free from crusts or scales; left side

of forehead, at junction of the scalp, some five or six papules, large, flat, and sharply defined, extending slightly into the hair; on face, left side, below nose, two or three flat, infiltrated papules. Same condition exists at angle of jaw, right side. On neck about ten groups of infiltrated papules, each group varying in size from a silver dime to size of silver quarter; color, from pale to dull red. On back, disappearing plaque composed of five or six small pale papules, situated on right side about four inches below and internal to angle of scapula. Anterior aspect of thorax and abdomen free. On right arm, internal surface, above olecranon, some twelve to fifteen yellowish, fast-disappearing papules. On lower arm, flexor surface, about middle, five or six large, elevated, flat papules, indurated, and in connection with them a group of same, less elevated. On extensor surface of lower (right) arm are two plaques, size of a dime, and infiltrated; left upper arm a few faint, disappearing papules. On lower left arm, outer middle aspect, a patch the size of a silver dollar, made up of infiltrated, elevated, sharply defined papules. On right lower leg there is, at junction of middle and upper third, over the crest of tibia, a cicatrix about three and a half inches in length by one inch wide, tense, and adherent to periosteum. Periosteum thickened; not painful; lower third of tibia painful to pressure (periostitis). On left leg, on posterior surface, below popliteal space, four or five large indurated papules. On left thigh, three inches above the patella, six or seven large papules in a group of a diameter of one inch and a half. On the right thigh, three inches above the patella, about a dozen flat, non-infiltrated papules. On middle posterior aspect of thigh is a plaque of a diameter of two inches, composed of infiltrated and non-infiltrated papules.

March 28th: First injection right side, as in previous cases.

March 30th: Patient (unknown to me) had been taking mercury previous to entrance into hospital. To-day marked signs

of salivation. Gargle of chlorate of potash and alum pencilings.

March 31st: Great pain at site of injection. Not as severe as yesterday. Stomatitis; gums show considerable ulceration; *fætor ex ore*. Chlorate of potash gargles, and tannin and myrrh applied to gums.

April 2d: Stomatitis about same; pain in thigh and around site of injection considerable.

April 4th: Stomatitis much improved; pain less at site of injection; can now sleep on affected side; exanthem and induration very decidedly improved; has diarrhea to moderate extent. Second injection, in left side.

April 7th: Pain not nearly as severe as after first. Had severe pain during day and evening of 4th in left side. Feels sore, but pain not very severe except on pressure at site; can not lie on left side; pain on right side—site of first injection—scarcely less; stomatitis almost gone; syphilides much improved. On arms only pigmentary remains.

April 11th: All infiltration gone. Only flat pigmented marks at site of former papules. No pain, but objects to another injection; complains much of the suffering she has undergone from injections; says she must go home, and so is permitted to go.

LOUISVILLE, KY.

### BROWN-SÉQUARD'S ELIXIR VITÆ, OR THE LATEST FAD WITH MEDICAL MEN.

BY T. B. GREENLEY, M. D.

It has often been remarked that history repeats itself, and it would seem this trite saying is remarkably verified in the late experiments of Dr. Brown-Séquard as it respects his rejuvenating liquid.

Were it not for the high reputation of the doctor as a scientist and noted investigator in physiology, but little attention, I presume, would have been given his paper on the subject by medical men. Can it be that the doctor has advanced to the stage of life termed second childhood, and been deceived by his own imagi-

inings? He says his elixir, or fluid, is composed of four elements, (1) blood from the spermatic veins; (2) semen; (3) juice expressed from the testicle, and (4) water. In his own case he used about four volumes of water to one of the other ingredients combined. Of this compound he injected nearly a cubic centimeter at a time. These injections were repeated some five times between the 15th of May and the 4th of June. The next day after the first injection he was enabled to perform as much labor in his laboratory without fatigue as he was twenty years before. He is now seventy-two years old, and has very perceptibly lost physical force, especially in the last decade. He was now able to run up stairs as he had formerly done in his younger days. This strengthening influence continued for nearly a month, and on the 1st of July he reports that his former feebleness had returned.

We will now undertake to examine the nature of the fluid injected, and its possible effects. In the first place we notice the blood of the testicular veins. We must consider that this blood has just returned from the organs, and, of course, is loaded with *débris* or waste material no longer of any use in nourishing or invigorating them. It can not be as rich in nutritious elements as if it had been taken from the spermatic arteries, as that supply is the source of organic nourishment, and hence all the elements that serve to elaborate semen are derived from this supply. Next, the semen is used as a factor of the compound, and is of course the least as to quantity, though this would depend to a great extent on the time the animal might be kept from the female. Then by compression the fluid part of the testicle is expressed out, and we have the elements forming this wonderful rejuvenating liquid. To this mixture about four volumes of distilled water are added in order to dilute it sufficiently for filtering. When passed through common filtering paper it is of a reddish hue and opaque; but perfectly clear and transparent when Pasteur's filter was used.

Of this compound, from ten to fifteen drops were used hypodermically at first, in the left arm. The next day, as the doctor states, he felt greatly invigorated, and, as before re-

marked, could perform his ordinary task in the laboratory without fatigue.

Now, whence came this mighty strengthening influence? It is noticed that four fifths of the fluid is water, the other one fifth being made up of blood, semen, and juice of the testicle. Which one of these elements contains this great bracing virtue? We have seen that it was not in the blood. Can the infinitesimal quantity of the semen exert this great power? How much semen could there be left in the fluid after filtering? Could there be a half minim? I think not, as there are only three drops of all the elements aside from the water, and, as the semen is the most consistent portion of all, a part of it must necessarily be left in the filter. But admit this part to be equal in quantity to each of the other ingredients, to wit, the blood and the juice, then nearly one drop would enter the circulation. Now we will trace this infinitesimal quantity from the arm to the brain, where, of course, it has to go in order to produce its sudden and wonderful exhilarating effects through the nervous system. Of course it is taken up by the capillaries of the part, enters the veins, reaches the vena cava descendens, and is emptied into the right side of the heart, from whence it is sent through the lungs by the pulmonary arteries, thence to the left side of the heart, thence over the system generally, the brain receiving its due proportion. Now by the time this injection reaches the brain, how much of the one drop of the semen is received by that organ? Can it be that half or even one third of it gets to the brain? Say that it all reaches the left side of the heart, not more than one third of it could reach the brain through the carotids and vertebral arteries. Now when we consider the extraordinary effects alleged to result from this insignificant amount of semen we are amazed, and wonder how such results are possible. Either one of two things must greatly aid in apparently effecting such wonderful results. If it is the effect directly of the injected material, we must conclude that it acts as a ferment in the blood, reproducing its own elements in large quantities and in a rapid manner, or the whole thing is mainly the result of the imagination. If we eliminate these hypotheses, we then are neces-

sarily bound to accredit the claimed results to supernatural agencies, which, of course, no one will believe in this late age. But suppose the little dose of testicle juice should so act in the brain and cord as to stimulate the trophic nerves and renew muscular power in old and feeble persons, how would common sense induce us to believe such increased power would continue from one injection, or from four or five, used at intervals of several days? It surely can not act in the same manner as electricity, spasmodically and momentarily. Then, again, how can it act for any length of time unless a new cellular structure of the muscles could be formed in place of that existing? These cells are fed by nutriment pabulum passing through the capillary circulation, of course under nervous influence.

But is it reasonable to suppose that in such a short time new cells could be constructed and vivified by this wonderful fluid, so that new life and activity could be imparted to the animal? I think not. This could hardly be done if the fluid was administered in large quantities.

But the question might be asked, why is there so much rejuvenating power contained in the testicles of animals? \*

Dr. Brown-Séquard maintains that the semen retained any length of time changes the nature of man; that is to say, if a young man is continent for some time, say several years, he is in a state of excitement, and possesses greater mental power and physical activity. This as a rule may be so, but as far as my observation extends it is otherwise; but does it hold good when applied to the inferior animals? When we refer to the horse we note no difference as to physical endurance between the gelding and the stallion. And I am not sure that incontinence in man renders him less excitable or diminishes his mental or physical powers unless carried to excess. The reproductive act is natural, and should not impair any function, mental or physical. Then, as before asked, whence comes the great vivifying force alleged to exist in the semen? The same character of blood that supplies and nourishes all other organs of the body affords nourishment

to the testes. This being so, there must exist some inherent power in the organs themselves by which this great rejuvenating and vivifying substance is generated.

Semen, like the products of all glandular organs, is secreted directly under the influence of the nerves of the part; then, reasoning *à priori*, we might expect to find in the nerves supplying these organs, from the periphery to the center, as much vivifying influence as in the product of their agency. Or, to extend the matter further, might we not expect to find as much or more of this special material in the brain itself, which is the chief seat of nervous power and vitality? It is a great wonder that some of the experimentalists have not injected brain juice before now. Reasoning on the principle of induction, if the strength and physical power of man are contained in his semen, and by injecting it in old and feeble people we restore lost power, we should expect an injection of brain matter, which is the seat of mental power, to greatly increase this function in mentally impaired or weak-minded people. This idea would be in accordance with the practice of Pasteur in his inoculating experiments against hydrophobia. He takes a portion of the medulla oblongata of the rabid animal, simply because that organ is the seat or center of convulsive movement. Then, reasoning on the same principle, we would take a portion of the cerebrum (being governed by whatever faculty we wished to improve) and inject it hypodermically; and if we wished to restore lost virile power, we would, of course, use a portion of that part of the cerebellum that supplies aphrodisiac force. But is not the whole theory an absurdity?

The powers above alluded to, centralized in the various parts of the brain, are manifested through the medium of the nervous system; whereas, if a portion of the brain from the seat of either of these functions was injected or introduced into the circulation, it would, of course, reach the nerves controlling these functions through the medium of the blood. Here the question comes up, can the blood perform any other function than that of stimulation and nutrition? If not, how can it excite the functions alluded to except by cell formation

\* Dr. Brown-Séquard used the testicles of dogs.

or growth? And, as before remarked, the nutritious element in the infinitesimal portion injected could do but little in that particular in any one locality of the body. Now, can there really be derived any special result from this hypodermic injection more than an ephemeral stimulant or exhilarating effect, such as we get from the various remedial agents we are accustomed to use for such purposes?

It is well known to all who use the hypodermic syringe, that the only difference between injecting medicine under the skin and exhibiting it *per os* is, that the effects are produced in a much shorter time, and that the dose required is smaller, but the physiological effects are the same, and do not vary from their known properties on account of the mode of administration. Stimulants or excitants act in a similar manner. We can also, to some extent, administer nutrients with benefit under certain circumstances, but they act under the skin as they do when administered by mouth. Then, is the so-called liquor of Brown-Séquard so different from all remedial or nutritive agents hitherto known to the profession, that an infinitesimal quantity should produce such wonderful or unheard of effects? What can there be in the few drops of juice and blood added to the particle of semen to rejuvenate the whole body in such a very short time (a few hours)? As before remarked, it can not be due to its nutritious effect, for it has not time to act in that way. Then, can its stimulating effect, if it is due to this property, continue for days? One would think not. Then we must say the greater part of the reported effects must be due to the imagination. By observation it is known to many members of the profession that we may inject simply water into the arm of a person who is under the morphia habit, telling him we are using morphia, and through the imagination he will be affected as though he had taken the drug.

The history of medicine affords ample evidence that the imagination plays an active part in respect to the effects of drugs and other remedial agents.

Even as late as the seventeenth century a great many agents were used as remedies which at present would seem to us not only worthless

but nonsensical and vulgar.\* Peacock's dung was used for vertigo and epilepsy. It was dried, powdered, and steeped in wine, and used internally.

The stercurus of the raven was also used for pain and cough in children, being hung about their necks.

Noctua, or owl's flesh, was used for melancholy. This remedy must have been used on the principle of *similia similibus curantur*, as the owl is the most melancholy of all birds.

The flesh of the viper was used to strengthen the nerves; said to act both as a diuretic and diaphoretic. The salt of the viper (whatever that may be) was highly recommended in inveterate cases of pocks.

Toad, dried, and hung at the breast, was good for stopping violent bleeding.

The penis of the hippopotamus, rasped and boiled in any liquid until it becomes viscous or thick, was good for stone or gravel. One would have supposed that in those times this would have been a good remedy in impotence.

Crayfish, powdered, was good for asthma and colic.

Wood-lice were recommended for gravel, asthma, and obstruction of the menses.

It must be remembered that these remedies were in vogue during the eighteenth century, more than one hundred years after the birth of the great Sydenham and other prominent physicians.

At the present time one would suppose that our credulity would be greatly taxed to repose confidence in the use of any of these substances as remedial agents. Yet, are not many of the people, and some pretended scientists of to-day, reposing confidence and much faith in the supposed virtues of just as absurd agents and means used as remedies for disease as those just alluded to?

We only have to speak of the Christian science treatment, the faith cure, the clairvoyant plan, the mind cure, the Dr. Flower plan, the high-potency treatment of the homeopaths. There are just as good grounds for belief in the owl, the hippopotamus, or the Brown-Séquard plan, as in any of those just enumerated. It may be said that a large majority of that class of peo-

\*See Bradley's Lectures, 1750.

ple who have faith in these various plans or modes of treating disease are ignorant or uneducated, but this remark will not apply to many of them. There are many learned and well-to-do people who employ homeopathic physicians, and some who submit to the other methods of treatment alluded to.

Then, it may be asked, what of the mental state of those who believe these dogmas? There are many well-educated and intellectually brilliant men who practice homeopathy, and no doubt really believe in the efficacy of their treatment. This remark will also apply to some of the other so-called dogmas in medicine. But then, this much admitted, it may be further asked, are such mentally cultured men earnest and sincere in what they teach and practice? I can not but believe that a great majority of them are. But, on the other hand, it is clear that some of them are aware of the fact that they are practicing a fraud on the credulity of their patients.

I believe, as a rule, the people place more confidence in the remedial virtues of medicine than the profession, and that is one reason why they so readily take up with any dogma in medicine that may happen to present itself. They are prone to believe in any thing to which a mystery attaches itself. For instance, a long-haired man, dressed in Indian garb and driving a team tandem, proclaiming himself an Indian doctor, who was raised with Indians, and familiar with all their remedial agents and plans of treating disease, can collect as big a crowd as a country circus. He inspires not only public respect, but admiration, and whatever he says is taken for granted as being true as gospel.

Then, again, a great many people have faith in the virtues of a patent medicine without knowing any thing of the compound, and will swallow it down regularly for some imaginary disease until they become really diseased from its excessive use, some instances of which have come under my own observation.

But to the subject of the rejuvenating elixir. It is very palpable that Dr. Brown-Séquard has made a greater discovery than he gave himself credit for. He only claims for the liquid an invigorating or strengthening effect,

whereas some of our American physicians have attributed to it great remedial efficacy. It has, under their administration, relieved rheumatism, restored to use paralytic limbs, and produced other miraculous effects. Most of the results of such experiments have appeared in the secular papers, not, indeed, with the consent or connivance of the doctors, but mainly through the energy, watchfulness, and perseverance of the news-gatherers. They are always on hand to grab every thing, scientific or otherwise, in the way of news, and perhaps many times magnify small things into big things. I do not think it is on account of any pruriency on the part of the physicians to get their names and experiments before the public that such things are published in the secular press, but, as before remarked, I charge it to that insatiable greed the reporters have for the collection of news. I am personally acquainted with some of the physicians who have experimented with this elixir, who are retiring in their habits, and would be greatly averse to such publications in the daily press. In fact, there are very few men in the profession who like to have their names paraded before the people in such a manner. Our inherent modesty forbids such a thing.

I remarked, in the outset of this paper, that history frequently repeats itself, and that the saying held good in regard to the vital elixir. It is said that the testes of various animals, more particularly those of the wolf, were used as aphrodisiacs during the time of the Roman Empire. But during those days the material was cooked and eaten, hypodermic injections being unknown. However, it required much more of the material taken in that way than by the present mode of exhibition. History does not record how many of the Venus worshipers among the officers and great men of Rome used the aphrodisiac, but it is imagined among so luxurious a people as the Romans were at that period of their history that it was not a small number. At all events, it must have engaged the industry and genius of many trappers in the mountains to have furnished a supply.

We have no account of the manner in which the testicles were cooked, or what kind of sea-

soning was used to make the *menu* palatable, but we are bound to infer, from the well-known epicurean taste of the people, that they were not eaten raw.

In speaking of the history of these materials as aphrodisiacs we can only infer, as our data is imperfect, who in those days used such aids to virile power. Of course the use of such things then, as now, was practiced very secretly. We are satisfied, however, that Antony, Julius Cæsar, Cleopatra, and others, used them to a considerable extent; but it is to be presumed that notwithstanding their free use, virile ability failed with Antony and Cleopatra, since they both committed suicide.

It is supposed by some that such things were known as early as the time of David and Solomon; for, according to history, it is very palpable that they needed some artificial aid in this particular. David, however, seems to have come to the conclusion that it was all vanity and vexation of spirit, and stopped its use. As to Solomon, it is not known that he ever became disheartened, and no doubt he continued the remedy to the end.

In our own time we are aware of the fact that the late Brigham Young must have resorted to outside help in this particular; but he, as far as is known, never divulged the secret as to the character of the ingredients. It is surmised by some that his predecessors came into possession of this secret at the time of the excavation of the plates containing the religious doctrine of the Latter Day Saints. Whether or not it was a legacy of the kings of the Jews is not positively known.

Dr. Yandell\* says an aphrodisiac of this character was in vogue about the middle of the sixteenth century, under the name of diasatyriion—that of the Romans being called satyriion. This was a very proper name, being derived from Satyr, the mythical impersonation of lust. The diasatyriion consisted of the testicles of the skunk or polecat, but, as in the other case, it is not exactly known in what manner they were taken, but of course they were cooked, and required a greater amount of condiments to render them palatable. It is unfortunate that historians of that period were so remiss in trans-

mitting to posterity a more minute account of such important matters.

This fad of the Dark Ages, however, had but a short run, as the Pope soon learned of its practice, and by his edict it was abolished.

Burlesque aside: There are some agents which are recommended, and have been used as aphrodisiacs in modern times, and in the estimation of well-informed medical men but few, if any of them, have any special effect in that particular. I do not believe, in fact, that any remedial agent has yet been discovered that will exert a positive effect to produce sexual desire and the ability to perform intercourse in cases of complete impotency.

There is nothing like good nourishing food and good digestion to increase that power, or to restore it when lost. To be sure there are some stimulants and excitants exerting temporary effects, which may have an ephemeral effect, but this is exerted through the system at large and not locally.

There is but little doubt that this late elixir fad will soon, like many others in medicine, be numbered with the things of the past, and only be recollected as a chimera of the brain which now and then encompasses the minds of men. But it is to be hoped that if any thing new and startling is soon again to be sprung upon us, it will be divested of absurdity and vulgarity, unlike the present fad or the late Burgeon method of treating consumption.

WEST POINT, KY.

## OBSTETRICS AND GYNECOLOGY.

BY E. S. M'KEE, M. D.

A case of laparoto-kelyphotomy during an extra-uterine pregnancy which simulated a cyst of the ovary is reported by Artemieff in *Archives Russes de Tocologie*, January, 1889. In describing this operation Dr. Artemieff touched upon a question of the greatest importance, this was, at what time one could detach the placenta without risk of provoking fatal hemorrhage. He is of the opinion that at term there will be no danger from the detachment of the placenta. We have the case of fatal hemorrhage which occurred in the practice of

\*See American Practitioner and News, August 31, 1889.

Depaul, wherein he essayed to detach the placenta the thirteenth day after the operation of laparotomy (four months after the death of the fetus), also the case of Professor Schroeder, who observed one hemorrhage the ninth week after the death of the fetus, in practicing laparotomy and extraction of the placenta. These could be explained by an accidental wound of a pelvic vessel in spite of the obliteration of the placental vessels achieved at this moment. The doctor arrived at the following conclusions: (1) Extra-uterine pregnancy can easily simulate a cyst of the ovary. (2) The diminution of the external dimensions of the wall is a symptom of great importance in the diagnosis of extra-uterine pregnancy. (3) In all cases of suspected extra-uterine pregnancy, to better decide the question, it will be necessary to have recourse to an intra- or extra-peritoneal explorative laparotomy. (4) If the existence of tubal extra-uterine pregnancy is decided upon, it is indispensable to terminate the explorative laparotomy by the extraction of the fetal sac.

Coition and conception take place under the most discouraging circumstances, and many and curious are the stories told about them. Congenital malformations of the vagina are unfortunate, but necessity proves the mother of invention. Carl Braun and Theodore Wyder have both reported cases where atresia existed and impregnation took place through the urethra, the vaginal canal opening into the urinary channel. Then we have the case where the vagina was closed, yet there existed a vesico-vaginal fistula behind the atresia. The male organ dilated the urethra, then entered, deposited the semen in the bladder, which sailed across the "briny deep," entered the vagina and went on to meet the ovule. One case, that of Louis, is reported where there existed a deep seated atresia of the vagina which opened into the rectum. This case was carefully discussed by theologians of a century ago, and finally resulted in a bull by Pope Benedict XIV, allowing in this case that as coitus took place through the rectum, by way of this channel it was also neces-

sary to deliver the child. Kroner's statistics tell us that only ten per cent of women who have vesico-vaginal fistula conceive. In many of these cases menstruation ceases and pregnancy does not occur. It would seem that the fistula alone is capable of preventing menstruation, and consequently ovulation. In some cases it must be admitted that ovulation continues, and the urine must be the preventive of conception. It is probably the acidity of the fluid which robs the spermatozoa of their independent power of action, or directly kills them. Simon, Febling, and Winkler report cases where conception takes place, though transverse obliteration of the vagina had been attempted on account of intractable fistula and only partially succeeded. Perhaps the urine had been retained in the pouch, become alkaline, and thus lost its fatal effect upon the semen. In some cases the urine probably acts as a mechanical preventive to conception by washing away the semen. Recto-vaginal fistula seem also to prevent conception, but the reason can not be determined unless the husband is thereby discouraged and disgusted.

Alcoholic drinks are considered by Duncan to have a bad effect on child bearing in women. It seems not necessary that the woman should be a drunkard, but only that she use alcohol immoderately. Perhaps it is a kind of overfeeding which is known to be detrimental to it, but this is hardly the only source of trouble. Cases are reported in which patients suffered from sterility, but physical examinations and other modes of inquiry have been unable to discover any evidence of disease of the internal genital organs, yet a change to habits of teetotalism was followed by conception. The use and abuse of alcohol, as we all know, produces, in addition to general or constitutional disorder, well-marked chronic ovaritis. This ovarian inflammation comes and goes as the patient comes and goes to her beloved drink. On the contrary, how often do we find in the squalid home of misery drunken parents surrounded by a houseful, or more probably a room full, of children always ragged,

Stenosis of the cervix as a factor in the causation of sterility in the human female has also been proven by cases in the lower animals. General Dumas, in his interesting work on the horses of the Sahara, gives us a long list of the remedies used by the Arabs in the so-called "buttoned-up mares" which seemed not remarkably rare. The principal operative procedure was to dilate the narrowed cervix with the hand or some hard instrument. Other veterinary surgeons, especially in France, as Andre, Eleonet, and Collins, found stenosis of the cervix and os a frequent cause of sterility in mares and cows. Manual attempts at dilatation in these cases have not infrequently proven successful. The Tyrolese peasantry have been in the habit of artificially dilating the os uteri by incision in cows, and have frequent successes. It has been observed that these stenoses in animals are chiefly acquired, the result of difficult labors with improper artificial assistance.

How variable is woman! Matthews Duncan reports the case of one in whom the easy birth of a single child exhausted the fecundity of a healthy woman of twenty-five years of age at the time of the birth, and completely ruined her general health during the remaining child-bearing period of life. This woman was examined by many physicians, and all concurred in finding no cause of the weakness and inability except the child-bearing. To offset this we have the case reported by Ansellin, wherein a woman married at twenty-one, and in twenty-seven years gave birth to twenty-five children, all of whom reached adult age, the mother dying at eighty-eight.

CINCINNATI, O.

DR. JAMES L. CABELL.—Dr. James L. Cabell died at Overton, Va., on the 13th ult. He was for more than fifty years identified with the University of Virginia in its department of medicine. He obtained his medical degree at the University of Maryland in 1834. He was made professor of anatomy and surgery in the University of Virginia in 1837, and held this place till the session just closed.

## Reviews and Bibliography.

**Kirke's Hand-Book of Physiology: Hand-Book of Physiology.** By W. MORRANT BAKER, F.R.C. S., and VINCENT DORMER HARRIS, M. D., London. Twelfth edition, rearranged, revised and rewritten; with five hundred illustrations. 784 pp. New York: Wm. Wood & Co.

Kirke's Physiology is too well known in the many editions that have led innumerable students into the domains of the most interesting of sciences to require extended notice at the hands of the reviewer.

The growth of physiological knowledge had outstripped the usefulness of the work as originally prepared, and the present authors set themselves to the task of revising the original work, and to select from the many new facts and observations which have been published within the last few years such as could most fitly find a place in a hand-book for students. This they have done in a most judicious manner, while at the same time preserving the terse and lucid style so characteristic of the original work. The student who selects Kirke's Physiology will not regret his choice. D. T. S.

**Cyclopedia of the Diseases of Children, Medical and Surgical.** The articles written especially for the work by American, British, and Canadian authors. Edited by JOHN M. KEATING, M. D. Vol. 1; illustrated. Pages, 992. Philadelphia: J. B. Lippincott Company. 1889.

The Encyclopedia of the Diseases of Children consists of a collection of monographs arranged in the form of a systematic treatise, and designed to embrace, in addition to the medicine and surgery of pediatrics, all the specialties tributary to it, as well as all collateral subjects of interest and importance, the knowledge of which might be of aid in treating children's diseases.

The student need scarcely go beyond these volumes for light on any subject that relates to the medical and surgical interests of children, such subjects as anatomy, embryology, and teratology receiving a good share of attention. Among the contributors to this

first volume are numbered such names as Angel Money, James Finlayson, E. O. Shakespeare, Theophilus Parvin, A. Jacobi, J. Lewis Smith, and many other of the leading authorities in both America and Europe.

Like all works of the kind, ground is often twice covered by the different contributors overlapping each other, and contradictory views are sometimes met. The latter can not, however, be considered a great objection, as medicine is yet too far from being a certain science to render it prudent for the student to accept the teaching of any author without question. Taken altogether, the editor is acquitting himself most commendably of the great task he has set himself to perform.

D. T. S.

**De la Lobeline dans la Therapeutique de l'Asthme:** Memoire presente an 1st Congres Bresilien de Medicine et Chirurgie, et lu devant le meme; Congres a la Seance du 15 Septembre, 1888. Par De Silva Nunes. Rio de Janerio: G. Leuzinger cie Fillros. 1889.

Dr. Nunes in this brochure emphasizes the value of lobeline for the relief and even cure of asthma. He finds the alkaloid much safer and more effective than the tincture, which had also proved valuable. To us of the United States, where lobelia has had its run as a household remedy for asthma, as well as for a multitude of other diseases, there is not a great deal in this echo from the tropics to instruct us.

D. T. S.

**Treatise on Hernia.** The Radical Cure by the Use of Buried Antiseptic Animal Suture. By HENRY O. MARCY, A. M., M. D., LL.D., of Boston, Mass. Pages, 251. (Physician's Leisure Hours Series.) Detroit: George S. Davis. 1889.

In this volume Dr. Marcy, beside reasserting his conviction that the best method of treating hernia is by the open-wound method and the closure of the parts with buried animal suture, collects a large number of reports from surgeons in many countries to prove the efficiency of his method. Dr. Marcy, in the course of his references, speaks

in a very complimentary manner of Dr. Greenville Dowell, of Texas. This has a grateful tone to those who had the pleasure of knowing that honest, simple-hearted, and at the same time skilful and original surgeon. This work of Dr. Marcy will add to his reputation and do good.

D. T. S.

**Extra-Uterine Pregnancy.** A Discussion. Reprinted from the Transactions of the American Association of Obstetricians and Gynecologists. Volume 1, 1888. With an Appendix, reviewing Mr. Lawson Tait's Ectopic Gestation and Hematocele. Pages, 66. Price, 75 cents. Philadelphia: William J. Dornau. 1889.

**Diseases of Women: A Manual of Non-Surgical Gynecology,** designed especially for the use of students and general practitioners. By F. H. Davenport, A. B., M. D., Assistant in Gynecology, Harvard Medical School, etc. With numerous illustrations. 12mo, pp. 317; price, \$1.50. Philadelphia: Lea Brothers & Co. 1889.

**The Urine, the Common Poisons, and the Milk; Memoranda,** Chemical and Microscopical, for Laboratory use. By J. W. Holland, M. D., Professor of Medical Chemistry and Toxicology, Jefferson Medical College, of Philadelphia. Illustrated. Third edition; revised and much enlarged. 84 pp.; cloth. Philadelphia: P. Blakiston, Son & Co. 1889.

**A Treatise on Surgery, its Principles and Practice.** By T. Holmes, M. A., Cantab., Consulting Surgeon to St. George's Hospital. With four hundred and twenty-eight illustrations. Fifth edition. Edited by T. Pickering Pick, Surgeon, and Lecturer on Surgery to St. George's Hospital. 8vo, pp. 1008; price, cloth, \$6.00; leather, \$7.00. Philadelphia: Lea Brothers & Co. 1889.

**Diabetes, its Cause and Permanent Cure,** from the Standpoint of Experience and Scientific Investigation. By Emil Schnée, M. D., Consulting Physician at Carlsbad, and Physician of the Imperial and Royal Consulate of Austria and Hungary, for the Rivera at Monaco. Translated from the German by R. L. Tafel, A. M., Ph. D. English edition, enlarged and revised by the author. 12mo, pp. 215; price, \$2. Philadelphia: P. Blakiston, Son & Co. 1889.

**A Laboratory Guide in Urinalysis and Toxicology.** By R. A. Witthaus, M. D. Second edition. New York: Wm. Wood & Co.

## Correspondence.

## PARIS LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

At the last meeting of the Congress of Dermatology and of Syphilography, which has just been brought to a close, a discussion took place concerning the treatment of syphilis, not that any new remedy has been discovered to dethrone mercury, the time-honored drug that has been employed for the cure of syphilis, but as to its proper or most suitable mode of administration. The following is the summary of a paper by Dr. J. Langlebert on the subject, or, more properly speaking, on the treatment of syphilis: (1) It is only when the prodromata of the secondary period (cephalalgia, rachialgia, general debility, fever, etc.) become manifest that the mercurial treatment of syphilis should be commenced. Corrosive sublimate, in doses of three centigrams per day, would, in the majority of cases, be the best agent. (2) The mercurial treatment should, in general, be continued during the whole duration of the first eruption. The dose of the drug should be gradually diminished when the spots or papillæ begin to disappear. (3) Mercury being an agent essentially active against syphilis in evolution, it should be reserved to combat the cutaneous or mucous manifestations of syphilis. It should not therefore be employed in their intervals. (4) Against the secondary accidents of the mucous membranes the local treatment is as important as the general treatment. (5) The mercury does not exercise against the secondary or tertiary manifestations of syphilis any preventive action whatever. (6) If mercury should be reserved to combat the syphilitic accidents in evolution, the alkaline iodides should, on the contrary, be prescribed when the syphilis is latent or in activity. The iodide is the remedy essentially of chronic syphilis. (7) Three years constitute the medium duration of the iodide treatment of latent syphilis. The intervals of rest should be equal to the periods of treatment during

the first two years; in the first year the medicine should be administered during three or four months. (8) With the exception of some special cases (acute secondary cephalalgia, marked nervous troubles, early tertiary accidents, syphilis being particularly grave, ulcers from the commencement), against which the iodides are more active than mercury, the iodide should be prescribed only after the end of the first eruption of the secondary stage. (9) The iodide is the remedy *par excellence* of tertiary accidents; it may also be preventive against these accidents. (10) If the mixed treatment (the iodide and mercurial) should be preferred against the onset of the tertiary accidents; it is by the iodide alone, continued for a long time, that a definitive cure can be obtained. (11) In the general treatment of syphilis the tonic medicaments, such as iron, cinchona, arsenic, sulphur, etc., combined with perfect hygiene and hydrotherapy, play, with these specifics (the iodide and mercury), a secondary rôle, but which are not the less of great importance. Many of the speakers proposed certain preparations of mercury which should be administered by the stomach alone, others preferred inunctions or hypodermic injections. Dr. du Castel said that he had observed two cases of death resulting from these injections, a third case was followed by albuminary nephritis, and terminated in death. He considers that these injections constitute a dangerous treatment. Dr. Mauriac finds that the preventive action of mercury and of the iodide of potassium is doubtful, he treats only the manifestations by the stomach. Injections and frictions constitute a mode of treatment that should be rarely adopted. Mercury should be prescribed as soon as one is certain that the chancre is syphilitic.

It is a fact of common observation that every new invention produces a new disease. Dr. Gellé, a well-known aurist, lately read a paper at the Society of Otology on the injurious effects of the telephone on hearing. Dr. Gellé stated that these accidents are due, in some cases, to the inten-

sity of the sounds, in others to the fatigue due to the attention necessitated by this particular mode of the transmission of sonorous impressions. In all the cases there is probably a certain nervous predisposition, and a pre-existing pathological condition of the organs of hearing. In a case observed by the author, a man of great mental power, and whose occupations necessitated a certain amount of intellectual labor, and particularly the audition very frequently of telephonic communications, the result was a condition of nervous excitement and auditory hyperesthesia, especially of the ear with which he was in the habit of listening. This gradually increased to such a degree that the sounds caused giddiness and buzzing, and finally persistent vertigo. The symptoms disappeared under the influence of rest. In another case, a girl, aged twenty-two, employed in a large office where the telephone was in constant use, loud buzzing noises in the ears became continual, and auditory hyperesthesia was so intense that hearing became acutely painful, the sharp tingle of the signal bell caused pain and giddiness, and a state of mental excitability of which she had shown no sign before. After a time the hearing of the ear with which she was accustomed to listen became much impaired, in consequence of which, and the unsatisfactory condition of her health, she was obliged to give up her employment, but after a period of rest she recovered almost entirely. In concluding his paper Dr. Gellé makes the following reflections: In such cases, together with the subjective symptoms, such as painful audition, noises in the ears, neuralgia, etc., the practitioner often finds sub-inflammatory conditions of the tympanum which may possibly have been induced by the same cause. If such a case is allowed to run on to what may be called its natural conclusion, the organ of hearing may be permanently destroyed, and the general nervous system become more or less involved.

Dr. Vidal lately had, in his ward in the Saint Louis Hospital, a patient presenting a syphilitic chancre on the lip of an un-

sual origin. The patient was a young girl of twenty-one years, who for the last three months, presented superficial lesions of the lips, particularly of the lower lip. These were taken to be eczematous. But, on her admission into the hospital, these became modified and presented an ulceration bearing the characteristics of a true chancre. This case was interesting, not only on account of the difficulty of the diagnosis, but on account of the conditions in which inoculation was effected. This young girl was working in a manufactory at the same time with a young man who had sore lips, and both had to use the same speaking-tube. It was by placing his sore lips on the mouth-piece of the tube that the patient got her chancre. If this be true, this mode of contagion deserves to be brought to notice.

PARIS, 23d August, 1889.

### Abstracts and Selections.

THE PREVALENT TREATMENT OF DIPHTHERIA.\*—Edward R. Squibb, M. D., writes in the *College and Clinical Record*:

The Kings County Medical Association recently concluded a discussion of diphtheria, which occupied, with interest and profit, six consecutive monthly meetings. During the time occupied by it, no less than five hundred and ninety-four deaths occurred from diphtheria in Brooklyn, in an estimated population of about 800,000. Many of the best and busiest physicians of this population took part in the discussion. All that is aimed at here is to give a brief abstract of the *materia medica* element of the discussion, so far as the principal agents are concerned, and these agents will be taken up in the order of frequency of their employment. This, however, may not be the order of their real importance in treatment, because some have a popularity from long-established use which may be yielding to more recent agents. In almost all cases more than one of the agents were used.

Alcohol was almost universally employed, generally as brandy or whisky, but with two very distinct objects in view; the greater number of physicians using it in moderate quantities as a stimulant and a food to support the failing powers of their patients, and in the more exhausting stages of the disease, and

\*An EpheMERIS of *Materia Medica*.

always as an adjunct to other active treatment; but many used it in large quantities from the very onset of the disease, as a special powerful antidote to the malignant poison of the disease, very much in the way that it is used in snake-bite. This treatment was pursued and strongly advocated by the late Dr. E. N. Chapman, of this city, up to the time of his death. Many have followed this use of alcohol, as the principal element in treatment, with encouraging success, but not generally with the success of Dr. Chapman. One busy and successful physician, who had long used this treatment, during an epidemic in his practice, awoke one night at 3 A. M. with easily recognized symptoms of diphtheria, including a membrane in the pharynx. He at once took half a bottle of brandy—probably about twelve fluid ounces. This, under ordinary circumstances would represent about 5.4 fluid ounces of absolute alcohol, or about the fatal dose. By 8 o'clock, or in five hours, he had finished the bottle of say over ten fluid ounces of absolute alcohol. After such a use of alcohol he was "at work again in a week," and he believes that it saved his life. And yet when in health half an ounce of brandy makes him feel heady. Most of those who used alcohol in this way testified to the absence of any signs of intoxication when the disease was at all pronounced in degree; and any signs of intoxication or odor of alcohol on the breath were regarded as the limit of dosage. From six to twelve fluid ounces of brandy in the twenty-four hours were not infrequently used on children from six months to three years old, though in the larger part of a general experience much smaller quantities were required—but always alcohol from the first in liberal and frequent doses.

Tincture of the chloride of iron was perhaps the agent next most commonly used as a principal element in treatment by the greatest number of practitioners, and this was always used freely as both a local and systemic agent. Though rarely used alone, there was much testimony in its favor, and none against it. It was simply losing ground to agents that were gaining in popularity.

Corrosive sublimate, or mercuric chloride, was very largely used as a local application by spray or gargle—about 1 to 500 for spraying, and 1 to 4,000 for gargling. A large number of physicians used this agent locally, and a smaller number used it systemically. In no case had there been toxic effects, and in one case only there was mild salivation, and the experience from its use was generally favorable. When used internally, the doses were generally small and frequently repeated, and the administration was carried to the pro-

duction of the characteristic diarrhea with green stools.

Attention was called to a recent paper on "Mercuric Bichloride in Diphtheria," by Dr. John S. Coleman, of Augusta, Ga., published in the *Journal of the American Medical Association* for February 23d, 1889. Dr. Coleman claims for mercuric chloride what has been by others claimed for alcohol, that diphtheria establishes a tolerance of the agent, and certainly his experience tends to sustain such a claim. Among other cases he relates one of a child, sixteen months old, who took corrosive sublimate in doses of one eighth of a grain hourly for seventy two consecutive hours—nine grains in three days—with the result of complete recovery after expelling a large tube of laryngeal membrane. This was his largest dosage, and his worst case, but other children took very large quantities with similar results. A child of three years took six eighths of a grain in six hours, and a total of 10.5 grains in nine days. Any such quantities in healthy children would probably prove fatal. Dr. Coleman does not always use such doses, but begins with one thirty-second of a grain and increases until the disease is counteracted.

Peroxide of hydrogen, or hydrogen dioxide, was presented during the discussion, as having been used both locally and internally in the treatment of diphtheria, as being one of the most active and energetic antiseptics known. It was subsequently used by several of the members, and the reports of its use then and since have been very favorable. Without being new at all, it is being treated as a novelty, and many very extravagant statements are being published by the makers of it, so that it is feared that this may prejudice the use of what should be a very valuable agent not only in diphtheria but in many other septic conditions.

As an ultimate result of the whole discussion it may be fairly stated that with the use of these agents, judiciously applied, the fatal cases of diphtheria, in the hands of those who discussed it here, were very far below its general mortality; and as this came to be apparent from the discussion it was questioned whether this was the result of treatment, or whether it might not be the result of a milder form of the disease in the classes of the community among which these physicians practiced. There was, however, no doubt left in the minds of any as to the value of treatment in contrast with expectant nursing of the sick.

#### THERAPEUTICS OF INFANCY AND CHILDHOOD.

A. Jacobi, M. D., late President of the New York Academy of Medicine, writes, in the *Archives of Pediatrics*, as follows:

I have given the reasons why chloride of sodium ought to be added to most foods of infants and children. For instance, vegetable diet contains more potassium and less sodium than all varieties of milk, and milk of herbivores more potassium than that of carnivores. The amount of salt contained in woman's milk depends greatly on the presence of salt in her food. Thus many a defective milk can be remedied by the mother or wet-nurse adding salt to her food. Particularly is that necessary in dyspepsia and gastric catarrh in the baby, one of the main symptoms of which is the presence of large and hard curds in the masses brought up by vomiting or evacuated by the rectum. The addition of chloride of sodium to milk impedes or delays the solid curdling by rennet, a physiological fact which explains the usefulness of salt in every kind of infant food.

Acidulation in milk will be prevented by boiling, mainly through the expulsion of a large quantity (three per cent) of gases (carbonic acid, nitrogen, and oxygen) contained in the milk when it leaves the udder. Parasitic growths are destroyed by boiling. Thus I have always advised to boil the milk destined for the use of a baby as soon as obtained, fill it hot into bottles, containing from three to six ounces, up to the corks, close them tightly, and preserve them inverted in a cool place. Whenever a meal is to be prepared, the milk thus preserved ought to be heated again up to or near the boiling point, preferably in a water-bath. That process ought to be repeated perhaps several times a day; while one bottle is being heated the others may undergo the same procedure, for every boiling interrupts the beginning of lactic acid or other decomposition. The sterilization of milk in Soxhlet's apparatus, manufactured for that special purpose, and recommended and introduced in New York by A. Caillé, is a still better contrivance. Milk properly sterilized will keep one or more days, but for general use among those who can not obtain or pay for the patented apparatus my method will suffice under ordinary circumstances and for people with the most ordinary intellect.

A certain amount of starch is digested at the very earliest age, for saliva is secreted at that time. Its effect persists in the stomach as long as the percentage of hydrochloric acid in the gastric secretion does not surpass 0.06; within the first half-hour of the digestive process there is none at all but organic (mainly lactic) acid only. Thus, though starch pass the oral cavity rather quickly, it will still undergo its change into dextrin in the stomach. In many abnormal conditions this digestive

change lasts a still longer time: thus in fevers, severe gastric catarrh, and in dilatation of the stomach. These are the very conditions in which farinaceous foods are best tolerated, for the reasons that the diastaltic effect of the saliva is not disturbed, and that albuminoids could not be digested because of the absence in these conditions of hydrochloric acid (and pepsin). In all normal and many morbid conditions the presence of certain quantities of amylaceous foods has some more functions. Besides being nutritious in its own way, starch serves to dilute cow's milk, to reduce the percentage of the mixture in casein, to prevent the latter from coagulating in large masses, and thus to render it more digestible.

Unless woman's milk can be had there is a great danger in the probability that the sensitive intestinal tract be supplied with injurious material. For such is the very best cow's milk in the cases of very young infants, because the mixture of its constituents differs greatly from that in woman's milk, and its casein is less digestible. Both physicians and manufacturers have tried to compound substitutes for woman's milk, but those only the composition of which is known must be noticed by scientific men and recommended. Another requisite is this, that such a food must be within the means and understanding of every body, and that a certain supervision be possible.

Cow's milk must be fresh, and not yet acidulated. The difficulty of obtaining it has led to the introduction of condensed milk. It is certainly preferable to bad cow's milk. But its composition is not uniform; there is a surplus of sugar, and therefore condensed milk may be permitted in individual cases, though not advised as a general and regular food for infants. Theoretically, it is an improper food because of its constituents; practically, it is known to give rise to digestive disorders and rachitis.

As long as a baby is not nursed by a healthy woman, the opportunities for acquiring some kind of gastric disorder are very numerous indeed. Dyspepsia is therefore quite frequent. Its treatment consists in more or less abstinence, and in the regulation of diet. As the gastric contents of infants who have been brought up on artificial foods is liable to be very acid alkalies in small doses, and frequently administered, have a good effect. Bismuth may be added. When there is vomiting, it must be determined whether it is gastric, and from what cause. Those who have been in practice know too well how often they have seen menigitis taken for a gastric disorder, and how common is the occurrence of that symptom in the incipient stages of all kinds of inflammatory fevers.

When all these and the local irritation of the stomach (brought on, for instance, by the presence of ascarides) and nephritis can be excluded, only then the vomiting ought to be considered as gastric only. Now and then abstinence only; or the drinking of warm water, or warm mustard water, to facilitate vomiting; or alkalies, or alkalies with bismuth; or resorcin to disinfect the contents; or dilute hydrochloric acid to correct the nature of the gastric acid; or the washing out of the stomach with warm water, or with an alkaline solution, or with a solution of one or two per cent of resorcin in water; and, finally, after the stomach has been freed of its injurious contents, small doses of opium (from one hundredth to a fortieth of a grain every hour, or its equivalent in morphia or codeia) will prove satisfactory. Protracted vomiting I have seen getting well with small doses of arsenious acid, from a thousandth to a four hundredth part of a grain every hour or every two or three hours, according to the age of the patient or the individual indications of the case. Small doses of ice-water or, better still, small ice-pills repeated every five or ten minutes, will answer in many instances. Effervescent drinks, iced, such as small doses of Apollinaris, Seltzer, or Vichy, or champagne, may do well in certain cases, but will do so less frequently and less happily than in most adults under the same circumstances.

In acute gastric catarrh, when produced by injurious ingesta, these ought to be removed. If vomiting have not occurred spontaneously, or not sufficiently, it must be produced by the above-mentioned drinks, tickling the fauces, friction of the precordial region, ipecac. (the syrup is very often an unreliable preparation), or other emetics. In cases of great urgency only the subcutaneous use of apomorphia may be resorted to. Purgatives must not be given in the beginning; large enemata will act more favorably. They may consist of warm water, warm water with antispasmodics, such as asafetida, or stimulants, such as turpentine. After a day or two a purgative dose of calomel will answer. Fever, unless it be high, requires no special treatment; in urgent cases only antipyrin may be given, either by mouth or rectum or subcutaneously. Tendency to convulsions requires cold to the head, or cold applications to the heart, which will reduce both the irritation of that organ and the temperature of the blood. A warm bath will often do good, mainly when the feet are warm, but the customary bathing and jostling and tossing of a baby in convulsions do more harm than good. Thirst must be relieved by water, carbonic-acid water, or water acidulated with hydrochloric acid (1: 3,000-5,000).

No solid food. Milk must be given in small quantities only, diluted with water, or lime-water, barley-water, or upon Rudisch's plan (dilute hydrochloric acid 1, water 250, milk 500). Vomiting is to be treated on the plan detailed above, predominance of acids by alkalies, constipation rather by calcined magnesia in small and frequent doses than by drastics. The aqueous tincture of rhubarb, in doses of from ten to thirty minims every few hours, will prove very satisfactory in many cases.

Severe forms of gastritis—the corrosive, diphtheritic, and suppurative varieties—require cold applications to the epigastrium, and opium in the most available form; in the beginning, subcutaneously. The corrosive form demands neutralization of the poison first: salt water for nitrate of silver, diluted acids (vinegar) for lye, alkali (chalk, magnesia, baking soda, soap) for acids, sulphate of sodium or oil for carbolic acid, egg, water, and milk for corrosive sublimate, etc. All of these require a total abstinence, which may be continued for more or less time. How long it ought to be endured depends on the condition of the patient and the good judgment of the medical adviser. Adults will bear it for many days, and infants and children from twelve to thirty hours. If such an absolute rest be demanded longer than this period, nutritive injections into the rectum must take the place of the introduction of food into the stomach. Now the rectum and the rest of the large intestine digests no albumen and emulsionizes no fat, but it transforms starch into dextrin, and cane-sugar into grape-sugar. Finally, it absorbs peptones of every kind, egg, emulsionized fat and starch. Starch-water injections are therefore more than merely soothing. Raw egg in salt water (salt 7 to water 1,000) or egg with a solution of ten or twenty parts of grape-sugar in one hundred of water (Ewald), with or without claret or brandy, the latter never in a high percentage, are easily absorbed. Water is received greedily. In all cases of rapid elimination of water by vomiting, or of utter exhaustion in gastro-intestinal catarrh with imminent thromboses in the small cerebral veins ("hydrencephaloid"), the hourly or bi-hourly injection of water, or a very mild salt water, into the rectum in doses of an ounce or more will fill the blood-vessels and restore the circulation.

Chronic gastric catarrh is sometimes dependent on or interrupted by acute catarrh; the attacks of the latter must therefore be promptly relieved. The several causes of chronic gastric catarrh have their own indications. Both in adults and children venous congestion resulting from pulmonary or cardiac diseases will give rise to it; thus in many cases digitalis in small

doses, continued a long time, will be the remedy or one of the measures of relief. Sedentary life must be avoided, school-hours and private lessons kept within reasonable limits, and regulated by the meals rather than that these should be controlled by the former. Masturbation must be watched: I have seen it to be the cause of gastric disturbances exactly as in adolescence. Diet and food want attention. Most children eat too much, and many too irregularly. Solid food is to be given but scantily; no sweets, no fat. Eating must be slow and mastication careful. Toasted bread or stale wheat bread, milk diluted with cereals or according to the muriatic-acid plan, or "peptonized" (every thing of moderate temperature or hot), will answer. Slowness of digestion, with heavy sensation about the epigastrium, demands additional chloride of sodium, bicarbonate of sodium, effervescent alkaline drinks; fermentation indicates resorcin, or creosote in doses of from one quarter to one half of a grain (minim). A few grains of salicylic acid diluted in large quantities of water (1:500-1,000) may be tried. Rhubarb and magnesium, rhubarb and bicarbonate of sodium, *tinctura rhei aquosa*, render excellent service. When there is a great deal of mucus, dilute hydrochloric acid with small doses of pepsin are indicated. When the tongue is thickly coated, with eructations, chloride of ammonium with *tinctura rhei aq.*; the tendency to vomit and pain demands bismuth, in older children Carlsbad, Congress, or stronger (bitter) waters. These measures may be continued for a long period; bismuth may be given indefinitely; sulphate of zinc may be administered (doses from one twenty-fifth to one sixteenth of a grain every few hours) a long time, nitrate of silver (doses of one thirtieth or one fifteenth of a grain several times daily) for not more than a week in succession.

Occasionally the irrigation of the stomach is resorted to with advantage.

In nervous dyspepsia therapeutics must be simple, yet the effect is not very encouraging. Food must be digestible and copious. Purgatives should never be given: enemata must take their place, if required. Bitter tonics, country and sea air, cold bathing or sponge baths, electricity, one large electrode being applied to the stomach and another to the spinal column, are indicated. In these cases, which are not quite rare among older children, particularly those with early and obstinate chorea and other symptoms of anemia and "neurasthenia," mild preparations of iron are among the very best remedies, and must be continued a long time.

Gastric ulceration, with or without hemorrhage, is not quite uncommon in children of

from seven to thirteen years. Fatal hemorrhages have been observed even in infants. No matter whether the cause may be found in an embolic process, or a chronic catarrh of long standing, or a local injury (caustic or foreign bodies, stones, a safety pin in a baby of eight months), the circulation in the parts is interrupted and the normal alkalinity of the tissues destroyed. Thus these are constantly exposed to the injurious effects of the gastric acids, similarly to what occurs in the dead body when the effect of acids in the non-secreting gastric surface results in softening and perforation of the wall ("gastromalacia").

Thus the first indication is to keep the stomach and duodenum as alkaline as possible, at all events between meals. Now, the introduction of any food will give rise to the secretion of gastric juice, which is acid, first by lactic, afterward by hydrochloric acid; a certain amount of these is required for normal digestion. Whatever there is, however, in the stomach of unnecessary acid or acids, which are not required for the physiological process, particularly the acetic, the butyric, caprylic, or only an excess of lactic acid, must be neutralized. An occasional dose of an antacid is not sufficient for that purpose, but it must be given regularly, and for a long time. I generally give the doses at intervals of two hours. I also give a dose a few minutes before each meal to neutralize every abnormal acid, no matter whether the patient may be an adult or a child.

Which antacid is to be selected, the potassium, sodium, calcium, or magnesium salts? Of the latter, I prefer calcined magnesium to the carbonate, as I do not wish the expulsion of free carbonic acid into the stomach. I use it frequently but rarely (for a child) in larger doses than from eight to ten or twelve grains daily. A small part of this, say one grain, is taken every hour or two, before meals, mostly in water, which should not be too cold; hot water is even better. More than that quantity is seldom tolerated, because of diarrhea setting in; still, its purgative effect is very welcome in patients suffering from constipation; these may take larger doses. When the above quantity does not suffice to neutralize the acids, or it is feared that more magnesium will cause diarrhea, it may be combined with the carbonate or the phosphate of lime. Sodium bicarbonate does not take the place of the calcium and magnesium so readily, inasmuch as it also appears to promote the secretion of gastric juice. Thus, in most cases, I use magnesium or calcium with or without bismuth, or such adjuvants, if any, as may appear to be indicated for other reasons.

This medicinal treatment must be continued for weeks or months; without it I do not see gastric or duodenal ulcers getting well.

The Carlsbad waters, and also the salines in general, owe their effect partly to the neutralizing and partly to the purgative influence they exert.

The use of lime-water is in part an illusion, if given for the purpose of neutralizing the acid. It is a failure because it contains only a single grain to nearly two fluid ounces of liquid. But when added to cow's milk in sufficient quantities (1:3-6) it certainly makes it more digestible.

The very function of the diseased organ involves danger. Both the stomach and the duodenum should be kept as idle as possible, and their labor should be made easy. Undigestible food must not be given, and solid food must not be allowed. In most cases older children tolerate boiled milk, strained oatmeal, barley gruel, stale wheat bread, and a few also raw beef. Some take nothing but boiled milk, buttermilk, or kumyss. Many, particularly convalescents or adults, will tell you that they do not digest milk. That may be true, but then they gulped it down and it formed a large cheese-cake in the stomach that was not afterward dissolved and digested. They must boil their milk in the morning and heat it several times during the day almost to the boiling point. They must add a small quantity of table salt to it; also, in case the stomach is very acid, some bicarbonate of sodium, or calcium, or magnesium. They must not drink their milk, but pour it upon a plate and sip it with a spoon. Thus prepared they will digest it, particularly when it is not quite cold. In fact, many require their meals warm or hot.

For the purpose of easier digestion, milk may be peptonized, according to Fairchild's directions, or it may be rendered more digestible by the process recommended by Dr. Rudisch, or mixed with farinaceous decoctions as recommended above.

With an alkaline condition of the surface and an innocuous diet the ulcers have an opportunity to heal. Their recovery may be aided by the administration of nitrate of silver. A child may take from one thirtieth to one twentieth of a grain in a tablespoonful of distilled water four or five times a day, if possible, on a fairly empty stomach. Or a smaller quantity may be given in a pill with or without a small dose of opium, say one sixtieth to one fifteenth of a grain in each pill. Sometimes I give but a single dose at bedtime in addition to the alkaline treatment. Nitrate of silver must not be given beyond a reasonable time, to avoid argyria.

The tincture of iodine, in doses of from one to three drops for the adult, of one half to one drop to a child, well diluted with water, has often been recommended. Its action is probably antifermentative here as in chronic gastric catarrh.

When there is much pain and a great deal of acid or other secretion, opiates are indicated, mainly those which are very soluble. Chloral is tolerated badly.

Bad cases require rest in bed. The stomach will have a better opportunity to get well when at rest than when at work.

Thus it becomes necessary sometimes to abstain from feeding by the mouth altogether. Rectal alimentation then comes in to great advantage. In conditions of such genuine starvation the lymphatics are very greedy and absorption from the rectum is very active.

Ulcer of the stomach, in both young and old, being frequently associated with intense anemia the result in these, as in many other cases, is mistaken for the cause. Then iron, the great presumed panacea for anemia, is often introduced into the stomach which can not digest it, and in its attempts to do so pain, ulceration, and danger are increased.

#### NOTES ON SURGICAL QUESTIONS DISCUSSED AT THE PARIS CONGRESS ON TUBERCULOSIS.—

The proceedings at the recent Congress for the study of tuberculosis at Paris, concerned chiefly questions of heredity and the modes of propagation of that disease. Some papers on the surgical aspects of tuberculosis may claim notice. In tuberculosis of the foot in children, Redard recommended scraping the fungous granulations, scooping out of the diseased bone, and employment of the actual cautery in preference to extensive resections. Strict antiseptic precautions should be exercised, and after the second day he employed prolonged local antiseptic baths. Returns of the disease are treated in the same fashion and generally three or four operations of this kind suffice. Verneuil supported his views and laid stress on the necessity, in cases where sinuses exist, of rendering the parts thoroughly antiseptic before operation.

Arloing returned again to the question of the identity or non-identity of scrofula and tuberculosis. His previous experiments with the inoculation of strumous glands on guinea-pigs and rabbits had led him to the conclusion that the virus respectively producing these diseases might be distinct, this being based on the assumption that strumous glands produced tuberculosis in guinea-pigs, but had no effect on rabbits. In a

series of subsequent and more extended experiments he obtained the same results as F. Eve (see *British Medical Journal*, vol. 1, 1888, p. 788), viz., that in many cases strumous glands when inoculated produced tuberculosis in rabbits as well as in guinea-pigs, and hence he came to the same conclusion as the writer named—that there is no proof that the virus of adenitis is due to any other bacillus than that of Koch; further, that it was impossible clinically to distinguish between the innocuous and the more virulent forms of strumous gland disease. An extensive series of experiments on tuberculous disease of bones gave practically the same results, rabbits being affected in some cases and not in others. The subsequent history of seventeen cases operated upon, showed that the best results were obtained from those cases in which the morbid products were innocuous to rabbits and therefore less malignant.

Four cases of scrofulous or tuberculous lesions of the skin furnished by comparative experiment the diagnosis of scrofula (that is to say, rabbits remained unaffected, guinea-pigs took the disease), although certain of the patients had their lungs affected. This fact would appear to show that comparative experiment only furnishes a test of the virulence of the local lesion from which the material is obtained.

Lannelongue communicated three cases of peri-hepatic abscess in children due to hepatic tuberculosis. In each case the abscess was opened and rib resected, but death took place in all, in two cases the cause being pleurisy.

As the result of an extended series of observations founded on the autopsy of ninety-three infants, Babes made an important communication on the micro-organisms associated with tuberculosis in infants. In the majority of cases the micro-organisms of suppuration were present with the tubercle bacillus of Koch. In ulcerative diseases of the mucous membranes with tuberculous foci sapro-genic bacilli were present; while in tuberculous pneumonia, pleurisy, peritonitis, and tubercular meningitis, one finds micro-organisms which have the power of producing these maladies. The author concludes that tubercular lesions open the door to the entrance of other micro-organisms which aggravate the tuberculous process and the state of the general malady and are often the cause of septic and pyemic phenomena together with apparent parenchymatous degenerations of the organs of infants.—*Dr. F. S. Eve, Annals of Surgery.*

**ON THE DIAGNOSIS OF PANCREATIC DISEASE IN ITS BEARING ON THE SURGERY OF THE LIVER.**—The recent advances in abdominal surgery render every point of diagnostic import valuable, and thus all cases bearing upon points of diagnosis are noteworthy at the present time. The occurrence of clay-colored stools is usually accredited to some form of biliary obstruction, but that there may be other causes of these stools is rendered probable by a consideration of two cases read before the Royal Medical and Chirurgical Society of London on March 26, 1889, by T. J. Walker, M. D., of Peterborough. In these cases absence of color in the feces was persistent and there was no jaundice. At the necropsy a healthy condition of the bile ducts was discovered, but the pancreatic duct was obstructed. Dr. Walker concluded from his cases that the formation of the coloring matter of the feces depended on the mutual reaction of the bile and pancreatic fluid under the influences met with in the intestinal tract; also that in disease a deficiency of pancreatic fluid would, equally with a deficiency of bile, cause the pathological clay-colored stools, and lastly, that as (in his opinion) the coloring matter of the feces could not be produced without the aid of the pancreas, that organ must bear an important part in regulating what proportion of the bile entering the intestines shall be absorbed and what thrown off in the feces. Further reports of cases such as these would be extremely interesting; at the same time the greatest care should be taken that no extraneous cause of pressure on the common bile duct should be overlooked.

A case reported by Dr. Herringham before the Medical Society of London on April 30, 1888, bears on this point. In this case a man, aged sixty-three years, was seized with violent pain in the abdomen and rigors, becoming jaundiced after ten days. The liver was enlarged and the gall-bladder could be felt as a rounded tumor reaching to the umbilicus. A diagnosis was made of obstruction of the bile duct by a gall stone. Subsequently cholecystotomy was performed by Mr. C. B. Keetley. At the necropsy cancer of the head of the pancreas was found and the common bile duct was in a perfectly healthy condition.

It will be noticed that in Dr. Walker's cases there was no jaundice, while in Dr. Herringham's case it was present, and clearly also biliary obstruction. From all these cases it would appear that the condition of the pancreas may be of importance

in arriving at a correct diagnosis in a case of biliary obstruction or in a case presenting the symptom of clay-colored stools. The diagnosis of impacted gall-stones is, in the light of these cases, rendered more difficult. A therapeutic point of interest also arises, namely, that the beneficial action of mercury in biliary affections may be due more to its action on the pancreas than by its directly stimulating the secretion of the liver.

Pancreatic cysts may cause the same symptoms as were observed in Dr. Herringham's case. To assist diagnosis it is well to bear in mind the other symptoms of pancreatic disease. Too much stress is not to be laid on the presence of undigested fats in the feces. There is generally evidence of undigested nitrogenous matters as well.

Other symptoms are pain of a burning character at the epigastrium, sick-headache, vomiting, anorexia, emaciation, sallowness, or even bronzing of the skin, and edema of the feet.

Not unfrequently diabetes has been observed and diarrhea may occur from excess of pancreatic secretion. Pancreatic cysts, according to Professor Küster, when they form appreciable tumors, may be mistaken for hydatid cysts of the liver, mesentery or kidneys, lymphatic cysts or aneurisms of the aorta or its branches. In women they may easily be mistaken for ovarian cysts unless the direction of growth is clearly noted. Minkowski states that great assistance can be derived in diagnosing cysts of the pancreas by observing the changes in position which result from distending the stomach with carbonic acid by administering bicarbonate of soda and tartaric acid and by means of filling the large intestine with water. Under these circumstances a cyst of the pancreas behaves almost exactly like a tumor of the kidney, from which, however, it may be diagnosed by the symptoms mentioned above and by special symptoms referred to the kidney.

The fluid from a pancreatic cyst, if sufficient quantity is obtained by aspiration, will be found to exhibit strong power of digestion. The absence of hooklets will serve to distinguish it from the fluid of a hydatid cyst. The significance of persistent clay-colored stools as a symptom of liver disease is undoubtedly modified by a consideration of Dr. Walker's cases, and the presence or absence of jaundice concomitantly with this symptom should be carefully looked for. The clay-colored stools apparently owe their color not entirely to the absence of pig-

ment, but largely to the presence of unabsorbed fats. In healthy persons from 6 per cent to 10 per cent of the ingested fats are found in the feces, and in cases of biliary obstruction from 52 per cent to 78 per cent. (Müller.) The pancreatic juice acts upon the fats, but not sufficiently to render them absorbable without the presence of bile. On the other hand, in pancreatic obstruction, the fats lack the action of the pancreatic fluid, and if Dr. Walker be right in his contention that the pancreatic secretion is the efficient cause in the production of hydrobilirubin, the stools will be equally, as in biliary obstruction, clay-colored, both from excess of fat and absence of pigment. *Dr. H. Campbell Pope, Annals of Surgery.*

ON THE TREATMENT OF CHRONIC UREMIA BY MORPHINE.—Uremia is a poisoning of the nervous system, and the poisons are formed within the body of the patient. How is it to be treated? There are three principles: (1) To eliminate from the system the poisons already present; (2) to counteract the poisons; (3) to prevent the further formation of poisons. Treatment to be of permanent good must always be directed to the first and last aims. The first we attempt by promoting the action of the skin by hot-air baths, packing, etc., and by the use of diaphoretics, especially jaborandi or pilocarpine; by carrying off waste products and their decompositions from the bowels by means of hydrogogue cathartics and by increasing the flow of urine by vegetable and saline diuretics. The last aim, the prevention of the formation and the absorption of further poisons, by greatly limiting the nitrogenous diet, as by placing the patient on an exclusively milk diet, and by controlling intestinal decomposition by certain drugs. But while we are endeavoring, as should be done in every case, to get rid of the poisons and prevent further formation, our patient may succumb to the effects of those present. Here comes in the second principle of treatment, namely, the attempt to counteract the poisons. Every bane has its antidote. The counteraction of the poisons is not only of service in minimizing the effects of the poisons, but is of further help in enabling us to gain time to carry out the other indications already discussed. Thus in uremic convulsions experience has taught that the damaging and often fatal results are held in check by inhalations of chloroform, and by the internal or rectal administration of chloral. Morphine has been used, more especially by American physicians, for the

same purpose in these cases, and it is claimed with better results.

It will have been noticed that the most prominent symptom in the first case, and a distressing symptom also in the second, was difficulty of breathing—uremic dyspnea, or so-called renal asthma. This, in its typical form, is not a very common symptom of uremia, though I should not from my own experience have thought it was so rare as it appears to have been in that of Sir William Roberts. This uremic dyspnea merits some consideration. It generally comes on, often suddenly or rapidly, in the evening or early night, is often very intense, lasts for some hours, and gradually passes off in the morning. It returns night after night, and the patient may be quite free from dyspnea in the daytime. I have known such cases diagnosed as ordinary asthma, the renal origin being unsuspected. I have long been in the habit of teaching that, when such a case is examined at an early stage of the attack—that is, during the first few nights—it is remarkable how little is to be heard, differing altogether in this respect from the noisy cecooing ronchi heard in bronchial asthma. I am interested to notice that Dr. Carter makes the same observation. Dr. Sutton is the only other physician whom I have heard direct attention to this point. Later in the attack bubbling râles and crepitations are heard, indicating the occurrence of edema of the lungs. It was for this uremic dyspnea especially that the morphine was prescribed. I have for some years been accustomed to treat such cases, in addition to the measures indicated under principles 1 and 2, by means of amyl nitrite, nitro-glycerine, chloral with and without alcohol, ammonia, and ether, inhalations of oil of juniper, Himrod's cure, chloroform, etc. One of the worst cases of uremic dyspnea I have ever observed I saw recently with Dr. W. J. MacKenzie, of Liverpool road, Islington. I prescribed small doses of nitro-glycerine, frequently repeated, and, if it failed, morphine. The dyspnea was greatly relieved, I subsequently learned, by the nitro-glycerine. It will be observed that morphine was not prescribed in the cases I have narrated until several of the remedies above mentioned had been ineffectually tried. The relief afforded by the morphine was extremely prompt, and equally successful in each recurrence of the attack. I think all the facts of uremic dyspnea, its periodicity, sudden onset, and relief by antispasmodics, point to a spasmodic neurosis due to poisoning of the nerve centers. Dr. Carter, with, I think, great

probability in his favor, suggests that the spasm is of the blood-vessels rather than of the bronchial tubes. This accounts for the absence of auscultatory signs in the early stage, and I think the subsequent pulmonary edema is another point in favor of Dr. Carter's contention. The high arterial tension on which Traube and Dr. Broadbent have deservedly laid so much stress in uremia due to spasm of the arterioles and capillaries, the great rapidity of the heart's action, the cyanosis and clammy sweat noticed in Case 1, all support this view. Dr. Carter suggests the analogy between uremic dyspnea and muscarine poisoning, which Dr. Lauder Brunton has shown produces intense dyspnea by causing spasm of the pulmonary and other arteries. He further hints the possibility of neurine and choline—which have been separated from the human body by Brieger—structurally and morphologically allied to muscarine or some closely similar substance, being proved to be the toxic element which poisons the nervous system and gives rise to the dyspnea in Bright's disease when not eliminated from the blood. If this be the case, then, as Dr. Carter writes, we may anticipate the time when a physiological antagonist shall be discovered capable of unlocking the spasm and relieving the distress as promptly as atropine does in muscarine-poisoning. I venture to suggest that this is how morphine acts in relieving the dyspnea of Bright's disease. It counteracts the poison, whatever it may be, that causes the spasm of the pulmonary arterioles (or bronchioles).

Headache and convulsions are very common symptoms of uremia. The former was present in both my cases. The immediate cause of both headache and convulsions apart from or in connection with Bright's disease has been much discussed. There is a good deal of evidence in favor of arterial spasm being the immediate exciting cause of each. This does not of course explain the pathology of headache or epilepsy, because we have to look further back for the cause of the spasm of the arterioles. In uremia we have this to hand. We know we have a poison or poisons in the blood, and we have evidence of spasm of the blood-vessels, so that we are able to connect the cause with its effect. I am inclined to think we are justified in referring the relief of the headache as well as the dyspnea to the influence of morphine in antagonizing the poison.

Uremic convulsions were not present in my cases, but I shall immediately refer to

their treatment by morphine. The success of morphine in the treatment of uremic convulsions I should also refer to counteraction of the poison that excites spasm of the arterioles in the cerebral cortex, which is the anatomical substratum of the motor phenomena. As I have already stated, at the time I used morphine in the narrated cases I had only read brief references to the experience of Dr. Loomis and others in the treatment of uremic convulsions. I have since consulted the original paper of Dr. Loomis, which appeared in the *New York Medical Record*, 1873, p. 365. Here will be found some very striking cases, illustrating not only the safety but the advantage of the employment of morphine in the treatment of both uremic convulsions and of other uremic symptoms, some of which were present in my own cases. Dr. Loomis, writing on the employment of morphine when "premonitory symptoms of acute uremia were present, as well as during the active manifestations of uremic intoxications," says: "So far as I am able to judge its administration has been uniformly followed by good results. In no instance am I aware that I have caused a fatal narcotism." Loomis certainly has shown the courage of his convictions, for he has given half a grain of morphine in a single dose to a patient in complete coma; and what is more remarkable and important, with relief to the condition. Scanzoni appears to have been the first to use morphine for uremic convulsions, and Loomis mentions that he first gave morphine at the suggestion of Dr. Metcalfe. Loomis and his followers have administered morphine in doses of from half a grain to one whole grain by hypodermic injection. Quite recently Mr. Alfred Grace has reported two cases of puerperal convulsions treated by morphine. In the first he gave a hypodermic injection of one grain at a single dose, and later another injection of nearly a grain. In the second case a single injection of a full grain of morphine was administered. Both cases made a perfect recovery. Purdy advises beginning with one sixth to one fourth of a grain, and writes: "The range of utility and safety of morphine in uremia is strictly confined to the convulsive seizures. Its employment is improper in the state of pure coma or chronic uremia unassociated with convulsions." The cases chronicled by Dr. Loomis and those I now bring forward directly negative this latter qualification. After the statements I have quoted I shall hardly be accused of

bold or venturesome efforts. My friend and colleague, Dr. Ralfe, in the *Year-book of Treatment*, 1889, mentions that in a patient of his suffering from granular kidney, with dropsy and ascites, the subcutaneous injection of one sixth of a grain of morphia speedily relieved a persistent and distressing attack of renal dyspnea which all other means had failed to control, and the relief was continued for some days following without further recourse to the drug. But Loomis claims for morphia not only the relief of dangerous and distressing symptoms, but more decided benefit still. Writing of the hypodermic injection of morphine in such cases, he says: "The almost uniform effect of morphine so administered is, (1) to arrest muscular spasm by counteracting the effects of the uremic poison on the nerve centers; (2) to establish profuse diaphoresis; (3) to facilitate the action of cathartics and diuretics, more especially the diuretic action of digitalis."

Enough has, I hope, been said to justify the further trial of morphine in uremia. I am not advocating its employment to the exclusion of other remedies of ascertained utility in the treatment of Bright's disease and the uremia arising therefrom. The evidence I have adduced shows that in spite of the asserted danger of opium and its alkaloid morphine in patients suffering from renal disease, it may in suitable cases be safely employed, and afford relief in the very distressing conditions we often witness in Bright's disease. I do not recommend its indiscriminate use; and, in the light of the asserted susceptibility of patients with disease of the kidneys to the toxic effect of opium, it will be given with eyes open to its danger. It certainly afforded striking relief to the cases I have narrated; and though in these I can only claim a palliative and not a curative influence, they were cases which from their nature and degree no other result could be expected. In less advanced cases, where the kidneys are capable of recovery, better results may be hoped for, and, indeed, have been obtained.—*Dr. Stephen Mackenzie, London Lancet.*

**FOR A COLD IN THE HEAD.**—Rabow declares that a snuff made of 2 parts of menthol, 50 parts finely ground roasted coffee, and 50 parts powdered sugar is a sovereign remedy against fresh "colds in the head." The powder should be snuffed into the nostrils strongly and frequently.—*Medical and Surgical Reporter.*

# The American Practitioner and News

"NEC TENUI PENNÆ."

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D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } - - - Editors.

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## NEW HYPNOTICS.

The Lancet of the 24th ultimo publishes the following relative to chloralamide, a new synthetic candidate for professional favor:

"Drs. Hagen and Häfter, assistants in Professor Strümpell's clinic at Erlangen, consider chloralamide one of the most reliable narcotics, and recommend that it should be given in a slightly acidulated solution or in wine. They say that the most appropriate cases for its administration are neurasthenia, spinal affections, and heart disease, and recommend a dose of fifty grains. The drug, when it acts at all, produces the desired sleep in half an hour. Its administration in phthisis has not proved so satisfactory, as in some cases it did not act at all, while in others, though sleep was induced, considerable general malaise was complained of on waking. They also gave it, one morning, to three convalescents from syphilis, who had each taken a dose the night before with good effect. The result in all three cases was that the patients slept nearly the whole day without being deprived of their ordinary sleep the next night. Before the communication of the authors to the *Münchener Medicinische Wochenschrift*, experiments had been made altogether in twenty-eight cases

(twenty-five patients and three healthy people), embracing 118 doses of the drug. A decidedly narcotic effect followed in twenty-six cases, superior to that of other narcotics in sixteen, and almost equal to it in ten cases. Complete failure occurred in two cases only—one of paralytic dementia and one of advanced phthisis; in a case of acute myelitis the result was doubtful. In comparing the amide with the hydrate of chloral the authors decide in favor of the former, on account of its less unpleasant taste, and more particularly because its narcotic effect is decidedly greater than that of the hydrate. Undesirable effects are certainly less marked and of less frequent occurrence with the amide than with the hydrate. They consist generally of slight headache and a somewhat dazed feeling on waking, but such symptoms occurred in only three of the twenty-eight cases; once collapse was noted, which, however, could not with any certainty be referred to the drug. Patients do not become accustomed to the amide of chloral, so that the same dose, however often administered, always has the same effect. The authors point out that the drug has not, as a rule, any specific effect on pain or other symptoms; but they mention a case of cardiac asthma in which the pulse, which had been very unsatisfactory, improved and maintained its improvement."

In a recent number of the Philadelphia Medical News, Dr. R. R. Pettit reports a case in which death followed the exhibition of thirty grains of sulphonal. The patient was a woman, twenty-eight years of age. *The drug was given in doses of fifteen grains each, with an interval of an hour and a quarter between them.* This demonstration (and it is not the first) of the power of this much-vaunted new drug to kill under certain unknown, and so far unknowable, physiological conditions of the system, admonishes us that the ideal hypnotic has not yet been found, and should call a halt upon the present almost universal use of sulphonal in doses of a dram or more for the single night. There would seem to be little doubt,

from the hebetude, slight mental aberration, and vertigo which its victims so often exhibit on awakening from a sulphonal sleep, that the drug induces profound cerebral anemia, either by lowering the heart's action to a dangerous degree, or by spurring into tonic spasm the vaso-constrictor muscles.

Be its mode of action what it may, the thoughtful physician should have seen in such symptoms a signal of danger, and thereupon have refrained from placing his patients in even possible jeopardy. So far none of the synthetic drugs so much vaunted as hypnotics and analgesics (except urethane) have proved invariably innocuous in doses competent to produce appreciable physiological effects, and in view of this fact it would be well for physicians to await the decision of experts before employing them in practice. Almost every new drug of this class has found its victims among human beings through the overweening faith of physicians, and it is questionable if all the good done by some of them (and certainly some of them do no good) is worthy to be weighed against the life of any man, woman, or child.

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#### ARMY SURGEONS.

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The Army Medical Board has been ordered to convene in New York City, October 1, 1889.

We are informed by the acting assistant surgeon that there are now nine vacancies in the medical corps of the United States Army in the grade of assistant surgeon.

Elsewhere in this issue will be found a notice informing candidates how to secure an invitation to appear before the board.

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TRANSACTIONS OF THE AMERICAN MEDICAL ASSOCIATION.—Any member of the Association desirous of procuring volumes of the Transactions from 1844-82 at a reduced price, can do so by addressing the business department of the Journal of the American Medical Association.

#### Notes and Queries.

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PREVENTION OF TYPHOID FEVER.—The following circular has been issued by the Kentucky State Board of Health:

OFFICE OF THE STATE BOARD OF HEALTH, }  
BOWLING GREEN, KY., August 12, 1889. }

*To the Health Officials and People of Kentucky:*

This Board desires to call the earnest attention of our health authorities and people to the gradually increasing prevalence of and mortality from typhoid fever, and to the growing importance of a constant resort to the methods which modern scientific researches have suggested for the prevention of this disease.

These preventive measures are of the more importance to the State because directed against a disease especially prevalent and fatal among persons in the prime of life, who contribute most to the public wealth and prosperity. Considered purely as an economic problem, the feature of it probably least thought of by most people, the importance of this disease can scarcely be overestimated. Statistics show that ten persons are sick for every one that dies of this disease; and to say nothing of the cash value to the State of those who die every year, and it is conceded that the State has no more valuable property than that represented in its vigorous population, the loss of time and labor, and the necessary cost incurred in attention to those who finally recover, makes an annual tax upon our people of startling proportions.

Typhoid fever is probably the most preventable of all diseases, not even excepting smallpox. It is now known that, like cholera and dysentery, the germ or specific cause of this disease is contained in the discharges from the bowels of those sick of it, and that while other methods of introducing the poison into the system are possible, it most generally gains entrance through the medium of an infected water supply—usually the use of well-water polluted by fecal matter. This may be direct, from drinking such water, or indirect, as by using milk or other articles of food or drink from cans or

vessels washed in it. Ice from an infected source is also dangerous, since it has been proven that freezing does not destroy the infective principle.

While water from all sources of supply is liable to contamination, well-water is especially so, whether located in city, town, summer watering-place, or country. Thus, out of three hundred and fourteen cases occurring in Louisville in 1884, two hundred and ninety-eight of the persons used well-water habitually, and some of the other sixteen did so occasionally. In the now famous epidemic at Plymouth, Pennsylvania, involving the sickness of 1,104 persons, the death of 114, and an actual outlay in money of \$67,100.17, the outbreak was traced to the use of water polluted by the fecal discharges of one imported case of the disease. Facts no less convincing might be multiplied indefinitely if space permitted. In a smaller way they are common in the experience of most physicians in active practice.

Usually the wells are sunk near the kitchen, and in dangerous proximity to the privy and other sources of contamination. The well draws its supply from an inverted cone, having its apex at the bottom of the well and its base at the surface of the ground. In dry seasons this base is often extended until the well becomes a receptacle for the more or less perfectly filtered filth from all the sources found in the average back-yard, and the water, often sparkling in its apparent purity, becomes a culture fluid for any disease germs finding their way into it.

Two methods of prevention, having the same general object in view, are to be recommended. The first involves the thorough disinfection of all discharges from the bowels of typhoid-fever patients. This is best done by the use of a solution of chloride of lime, eight ounces to the gallon of water, using a quart of this solution for each discharge, and allowing it to stand in the vessel at least one hour before emptying. A solution of corrosive sublimate, two drams to the gallon of water, will answer the same purpose, but requires to remain longer in contact with the material to be disinfected.

Bed and body linen soiled by such patients should be disinfected by the use of the same solution or by boiling.

The second method relates to avoiding the use of suspicious water, and especially well-water, and, where this can not be done, to boil such water before it is used for drinking purposes. In the absence of a pure and well-guarded public water supply, properly stored cistern-water is probably open to least objection.

The effectual practice of these methods will require intelligent care and some expense, but it is confidently believed that their general adoption would result in the practical disappearance of a disease which is not only a disgrace to our civilization, but an annual scourge and tax upon the people of Kentucky, in comparison with which yellow fever and cholera sink into insignificance.

PINCKNEY THOMPSON, M. D.,  
*President.*

By order of the board.

J. N. M'CORMACK, M. D.,  
*Secretary.*

**A NEW SOCIETY IN TENNESSEE.**—The following call has been issued: "The members of the medical profession in Alabama, Georgia, and Tennessee are requested to meet in Chattanooga on the third Tuesday in October for the purpose of forming a Tri-State Medical Association. All will be admitted to the meeting of the Association, but the membership will be restricted to graduates of regular medical colleges in good standing."

This call is signed by committees from Jackson County, Alabama, Medical Society; Chattanooga, Tennessee, Medical Society; Cleveland, Tennessee, Medical Society; Cartersville, Georgia, Medical Society; Dalton, Georgia, Medical Society.

It is to be hoped that there will be a general turn-out of the profession. Papers of interest have been promised by prominent men.

This organization will be independent of all other societies. It will be an association of individual members of the profession of medicine, and will be managed in the inter-

est of medical progress. You are earnestly requested to be present and participate in the exercises.

The session will continue two days. If you desire to read a paper or exhibit a specimen, please notify the undersigned at an early date.

Another circular will be issued in due time announcing the titles and authors of papers.

FRANK TRESTER SMITH, M. D.,  
*Secretary of Committee.*

CHATTANOOGA, TENN., August 8, 1889.

**THE AMERICAN PEDIATRIC SOCIETY.**—This Society, which was organized in Washington, D. C., September 18, 1888, will meet at the Army Museum Building, Washington, D. C., on the 20th and 21st of September, 1889. One of the afternoon meetings will be held in the Johns Hopkins Hospital, Baltimore, Md., by invitation of the director of the hospital.

A. JACOBI,  
*President.*

**AMERICAN ACADEMY OF MEDICINE.**—The annual meeting of the Academy, for 1889, will be held at Chicago, Ill., November 13th and 14th, being postponed to that date by authority of the Council.

RICHARD J. DUNGLISON,  
*Secretary.*

PHILADELPHIA, September 1, 1889.

**THE ARMY MEDICAL BOARD.**—An Army Medical Board will be convened in New City, New York, October 1, 1889, for the examination of such persons as may be properly invited to present themselves before it as candidates for appointment in the medical corps of the army.

Application for an invitation should be addressed to the Secretary of War, stating date and place of birth, place and State of permanent residence, and accompanied by certificates, based on personal acquaintance, from at least two persons of repute, as to citizenship, character, and moral habits, from the professors of the medical college from which the applicant graduated, are also desirable. The candidate must be between twenty-one and twenty-eight years of age, and a graduate from a regular

medical college, evidence of which, his diploma, must be submitted to the board.

Further information regarding the examinations and their nature may be obtained by addressing the Surgeon-General, U. S. Army, Washington, D. C.

*Editors American Practitioner and News:*

In my article on Croupous Pneumonia, in your journal of August 17th, you should have inclosed in quotation marks all the matter, beginning with "Shall the elevation of temperature be controlled," down to the bottom of the column. The question referred to is in the first column on page 102. In the quotation made from Juergensen, wherein it is said that "whoever is timid where life is at stake belongs elsewhere than at the bedside," should be "whoever is timid when this is at stake."

ROBERT C. KENNER.

**ASSOCIATION AMERICAN PHYSICIANS.**—The annual meeting of this Association will be held in the Army Medical Museum, Washington, on September 18th, 19th and 20th, under the presidency of Dr. Francis Minot, of Boston. The programme has just been issued, and contains the following papers:

The President's Annual Address, by Francis Minot, of Boston.

The Early Stage of General Paralysis, by C. F. Folsom, of Boston.

Tetany, by James Stewart, of Montreal.

Tetany and a New Theory of its Pathology, by John T. Carpenter, of Pottsville.

Thrombosis of the Cerebral Sinuses and Veins, by A. B. Ball, of New York.

Chylous Effusions into Serous Cavities, by S. C. Busey, of Washington.

Substitutes for Opium in Chronic Diseases, by J. F. A. Adams, of Pittsfield.

Remarkable Case of Slow Pulse, by D. W. Prentiss, of Washington.

Discussion on the Relation between Chlorosis, Simple Anemia, and Pernicious Anemia, including Leucocythemia and Hodgkins' Disease. Referee, Frederick P. Henry, of Philadelphia; co-referee, F. Forchheimer, of Cincinnati.

Primary Cancer of the Duodenum, by E. N. Whittier, of Boston.

**Primary Cancer of the Gall-bladder and Ducts**, by John H. Musser, of Philadelphia.  
**Gastric Neurasthenia**, by G. M. Garland, of Boston.

**Specimens from Two Cases of Cretinism**, by W. F. Whitney, of Boston.

**The Anatomical and Physiological Relations of Lesions of the Heart and Kidneys**, by H. F. Formad, of Philadelphia.

**The Contagium of Diphtheria**, by P. Gervais Robinson, of St. Louis.

**A Supplementary Inquiry into the Frequency with which Lead is Found in the Urine**, by James T. Putnam, of Boston.

**Discussion on the Relations of Rheumatism to Rheumatoid Arthritis**. Referee, William Osler, of Baltimore; co-referee, Morris Longstreth, of Philadelphia.

**How Far May a Cow be Tuberculous Before the Milk Becomes Dangerous as a Food Supply?** by Harold C. Ernst, of Jamaica Plains.

**The Bacillus Tuberculosis**, by J. T. Whitaker, of Cincinnati.

**Hot-air Inhalations in Tuberculosis**, by E. L. Trudeau, of Saranac Lake.

On Thursday evening, September 19th, it is proposed that the Association shall have an annual dinner.

**CHINESE OBSTETRIC CUSTOMS AND SUPERSTITIONS**.—Dr. A. M. Fielde writes interestingly on facts and superstitions concerning pregnancy and parturition as observed at Swatow, China, in the Philadelphia Medical News for August 24th.

Nearly all the Chinese women maintain a sitting posture during labor and delivery. A few are unable thus to bring forth the child, and these are called "recliners."

The umbilical cord is never divided until after the emergence of the placenta, because it is supposed that this would cause the contents of the womb to rise and remain among the internal organs, causing speedy death. After the appearance of the placenta, the cord is tied by a thread, about one inch from the umbilicus; a loop is made by bringing the distal portion toward the body; a second knot is tied securely upon the first over the

double cord, "to prevent the entrance of wind," and the cord is then cut near the second knot. The part of the cord left with the placenta is not tied.

If there is much delay in the expulsion of the secundines, various methods are pursued in assisting the patient. The mother-in-law or midwife goes behind the house in which the patient lies, raps smartly with a carrying-pole on the wall, and shouts, "Is it out yet?" An assistant responds from inside the house, "It is out." This performance is repeated with short intervals, until the desired result is effected.

Another method of hastening the expulsion of the afterbirth is to have the patient lean over a horizontal bar, supporting herself partially upon her hands. This sometimes starts the adherent placenta, but is discomforting to the attached infant.

Some midwives insert the hand and detach the placenta, but mothers greatly fear this operation. It is asserted that one woman had her liver pulled out by the attending midwife, and consequently died. Native male physicians are under no circumstances called in cases of childbirth.

A girl that is born face downward, or one that is guilty of micturition or defecation immediately after birth, is straightway smothered, because of a superstition that such a child would be injurious to its parents.

A pregnant woman is advised not to handle edged tools. If she does so, her offspring is likely to lack a finger or a toe, or to have a harelip or a split ear.

Two pregnant women will not sit together on the same bench. As each woman hopes that her child is a male, and as it is thought that there may be an occult exchange of sexes between embryos that are brought into vicinage, it is considered wise to avoid the risk of having the supposed masculine tenant of the womb superseded by a female.

If a child has been touched by a pregnant woman, and sickens soon afterward, its mother winds a skein of silk, made up of threads of five colors, around a potato, and roasts the potato in ashes. If the silk is burned during the process of roasting, it in-

dicates that the ailment was not caused by the touch of the pregnant woman. But if the silk is not burned, as sometimes happens, then the mother of the injured child throws the potato over her house, and it is believed to produce a miscarriage in the woman who has caused the disease, while the sick child recovers.

Many men have purses made by women approaching confinement, hoping that the woman's plethoric condition will be mystically reproduced in the money-bag.

THE INSPECTION OF THERMOMETERS.—At the thermometric bureau of the Yale College Observatory, during the last year, the comparison of thermometers has continued to be made by Mr. C. B. Peck, says Science. The number received for verification during the year ending June 1, 1889, was 7,475, being 249 in excess of the preceding, the maximum year. It is perhaps well to call public attention to the fact, not new, but continually overlooked, that the most accurate thermometers may be made to give false testimony by misinterpretation of their language. Although every certificate issued from this observatory, for other than clinical thermometers, contains a statement of the only conditions under which the correction therein given can be truthfully applied, they are continually called upon to explain, especially in the case of high-temperature thermometers, that, when only the bulb is immersed in a liquid of high temperature, the indicated temperature is too low by an amount depending upon the number of degrees of the mercury in the cooler stem and the difference between the temperature of the bulb and stem. They have been called upon to show frequently that this error, which is independent of any correction due to the thermometer, may be as much as eight or nine degrees in the case of high temperature oils, as their temperatures are generally measured. A simple remedy for this indefiniteness of measurement would seem to be a special form of thermometer, in which nearly all the mercury should be immersed. Of the same nature is the cor-

rection of possibly  $0.1^{\circ}$  to be applied to clinical thermometers of the "indestructible index" form, when the detached column of mercury constituting the index is quite long (expressed in degrees), and is read after removal to a much cooler atmosphere; but the probable error on this account does not exceed the probable error of reading.

THE RABIC COMEDY AT JARVILLE.—The commune of Jarville, in Lorraine, near Nancy, has recently enjoyed a hydrophobia scare of quite respectable proportions. The cause of all the commotion was a little black puppy, about two months old, that belonged to the proprietress of a public house. The owner became ill, and, finding the puppy rather troublesome, made it over to a friend, who, in turn, transferred it to another, and so it passed through several hands in a short time. One of its owners was a drunken workman, who died from delirium tremens. The report soon spread that the man died from hydrophobia. The original owner, who had suffered for some time from cancer of the stomach, was so alarmed at this report that she took to her bed, and soon after had a final attack of hematemesis, to which she succumbed. Rumor assigned hydrophobia as the cause of her death also, and the town went wild. A large number of the inhabitants went to Paris, to the Pasteur Institute, at the expense of the commune, and after being inoculated returned home with minds at rest, and now propose to celebrate their deliverance by a *bal des enragés*. Thus ended, what Dr. Linet, who chronicled the event, has called the rabic comedy of Jarville.—*Medical Record*.

THE HYGIENE OF TUBERCULOSIS.—At a recent meeting of the Paris Academy of Medicine, M. Villemin read a report of the Special Committee appointed by the Congress for the Study of Tuberculosis last year, which it was proposed to publish, with the object of instructing the laity as to the nature of the disease and the best means of avoiding contagion. The report calls attention to the fact that pulmonary phthisis is not the only form in which tuberculosis manifests itself, but that many cases of pleurisy, peritonitis, meningitis, and bone

and joint diseases are often tuberculous. The report insists upon the contagiousness of the disease, and refers to the various ways in which the bacillus may gain entrance into the body. Since the sputa of phthisical patients usually contain the bacilli in large numbers, special care should be paid to the immediate destruction of all expectorated matters. The report also insists upon care in the matter of food, since milk, beef, and fowl are found not uncommonly to contain the bacilli. Milk should, therefore, be boiled before being given to children, and meat thoroughly cooked.—*Ibid.*

MESSRS. JOHN WYETH & BROTHER'S advertisement in this issue is worthy of the careful attention of our patrons; they give a complete list of their Compressed Hypodermic Tablets, embracing in all some seventy-one different agents and combinations, the most complete we have yet seen. In it will be found almost every medicament used in hypodermic practice. This house was the first to devise this most valuable and convenient form of subcutaneous treatment. The well-known reputation of this house is sufficient guarantee for all the claims they make for them, as well as for all their preparations, so widely and favorably known.

**A CASE OF INOCULATED LEPROSY.**—At the Dermatological Congress held at Prague recently, Dr. Arning gave an account of a case of inoculated leprosy in the Sandwich Islands. In 1884 he was permitted to inoculate a condemned criminal, with the latter's consent. The man whom he inoculated had no inherited taint. The immediate result of the inoculation was negative, but four weeks later the man was attacked with an affection resembling subacute rheumatism without fever. The first joint involved was the left elbow, and then other joints became attacked, the attack lasting for four months. Then occurred some swelling of the left ulnar and median nerves, which subsided in the course of six months. Meanwhile there had developed on the scar at the site of the inoculation a typical leprosy nodule, from which abundant bacilli were ob-

tained. Since Dr. Arning had returned to Europe he had learned that the disease had made considerable progress, and the unfortunate man was now in a condition of marked marasmus.—*Medical Record.*

A CASE is reported from one of the suburbs of Boston, in which a young man, suffering from typhoid fever, in his delirium shot and killed his nurse, a woman fifty years of age, and tried to shoot one of his relatives as well. A revolver had, it seems, been left where he could get at it. In the present season of typhoid prevalence too great care can not be taken to watch with unceasing vigilance patients who are or are liable to become delirious from this cause, and to keep them away from any opportunities of doing harm, in a sudden frenzy, to themselves and others.—*Boston Medical and Surgical Journal.*

DR. ALEXANDER BROWN MOTT, the well-known surgeon and physician, of New York, died on his farm at Yonkers, August 12, 1889, of pneumonia. Dr. Mott was in the sixty-fourth year of his age. He was one of the founders of Bellevue Medical College, and held the chair of Professor of Surgical Anatomy from the opening of the college in 1851 until 1872. During the rebellion he took quite a prominent part in the surgical service, and gained considerable distinction. He was mustered out of service July 27, 1865, with the brevet rank of Colonel.

A PHYSICIAN of Philadelphia insisted upon driving a fractious horse, and thus disregarded the suggestions of his coachman. The horse ran away, the coachman was thrown out of the carriage, his skull was fractured, and one of his legs was twice broken. Now the coachman sues the doctor, putting his damage at \$10,000.

It is reported, under date of August 22d, that James Brennan, a leper, escaped the Sunday before from quarantine at St. Louis, where he was confined for fourteen months, and is at large in that city.

THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.—The following is the preliminary programme of the session, to be held in Nashville, Tenn., November 12th, 13th, and 14th, 1889. The officers are: President, Hunter McGuire, M. D., LL. D., Richmond, Va.; Vice-Presidents, W. O. Roberts, M. D., Louisville, Ky., Bedford Brown, M. D., Alexandria, Va.; Secretary, W. E. B. Davis, M. D., Birmingham, Ala.; Treasurer, Hardin P. Cochran, M. D., Birmingham, Ala.; Judicial Council, John S. Cain, M. D., Nashville, Tenn., W. T. Briggs, M. D., Nashville, Tenn., J. M. Taylor, M. D., Corinth, Miss., DeSaussure Ford, M. D., Augusta, Ga., Virgil O. Hardon, M. D., Atlanta, Ga.; Chairman of the Committee of Arrangements, Duncan Eve, M. D., Nashville, Tenn.

The following papers will be read:

The President's Annual Address, Hunter McGuire, M. D., LL. D., Richmond, Va.

Report of Gynecological Work, with Especial Reference to Methods, R. B. Maury, M. D., Memphis, Tenn.

Direct Herniotomy, with Cases, W. O. Roberts, M. D., Louisville, Ky.

Open Abdominal Treatment, B. E. Hadra, M. D., Galveston, Texas.

The Abortive Treatment of Acute Pelvic Inflammation, Virgil O. Hardon, M. D., Atlanta, Ga.

The Importance of Early Treatment of Inflammatory Affections of the Uterus, Wm. C. Dabney, University of Virginia.

The Relation of the Nerve System to Reparative Surgery, Thomas O. Summers, M. D., Jacksonville, Fla.

Concerning the Causes of Frequent Failure of Relief of Reflex Symptoms after Trachelorrhaphy, W. F. Hyer, M. D., Meridian, Miss.

Cranial Surgery, DeSaussure Ford, M. D., Augusta, Ga.

The Treatment of Ectopic Pregnancy, W. H. Wathen, M. D., Louisville, Ky.

Laparotomy in Extra-uterine Pregnancy, Waldo Briggs, M. D., St. Louis, Mo.

Epithelioma of the Penis, with the Report of a Case, David W. Yandell, M. D., Louisville, Ky.

Laparotomy in Intestinal Obstruction, C. Kollock, M. D., Cheraw, S. C.

An Experimental Study of Intestinal Anastomosis, John D. S. Davis, M. D., Birmingham, Ala.

Operative Interference in Ascites, Hugh M. Taylor, M. D., Richmond, Va.

Observations Pertaining to Pregnancy and Parturition, W. Duncan, M. D., Savannah, Ga.

Puerperal Convulsions, John Herbert Claiborne, M. D., Petersburg, Va.

Some Remarks upon Aneurisms, Relating More Especially to their Surgical Treatment, F. T. Meriwether, M. D., Asheville, N. C.

Coccygodynia and Its Treatment, Hunter P. Cooper, M. D., Atlanta, Ga.

The Improved Cesarean Section *versus* Craniotomy, W. D. Haggard, M. D., Nashville, Tenn.

Conservative Surgery in Injuries of the Foot, J. T. Wilson, M. D., Sherman, Texas.

Gunshot Fractures of the Femur, John Brownrigg, M. D., Columbus, Miss.

Tropho-neurosis as a Factor in the Phenomena of Syphilis, G. Frank Lydston, Chicago, Ill.

Trophic Changes Following Nerve Injury in Fractures, with a Report of Two Cases, Wm. Perrin Nicholson, M. D., Atlanta, Ga.

Treatment of Malignant Diseases of the Rectum, W. T. Briggs, M. D., Nashville, Tenn.

The Achievements of Modern Surgery, J. Ewing Mears, M. D., Philadelphia, Pa.

The Treatment of the Pedicle in Suprapubic Hysterectomy, Wm. M. Polk, M. D., New York.

Papers have been promised by W. B. Rogers, M. D., Memphis, Tenn., L. S. McMurtry, M. D., Danville, Ky., E. J. Beall, M. D., Fort Worth, Texas, E. Burke Haywood, M. D., Raleigh, N. C., Paul B. Barringer, M. D., University of Virginia, J. F. Y. Payne, M. D., Galveston, Texas, and Joseph Price, M. D., Philadelphia, Pa.

A NEW and serious cattle disease, one of the effects of which is to leave the cattle blind, is said to have broken out in the vicinity of Lincoln, Nebraska.

# THE AMERICAN PRACTITIONER AND NEWS

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*Certainly it is excellent discipline, for we are sure to feel that he must see all he has to say in the least possible words, and his reader is sure to reap there, and in the present possible words, or his reader will certainly misunderstand them. Generally, also, a documented fact may be told in a few words, and it would doubtless facts at present were there in the case. RUSKIN.*

## Original Articles.

### RECTAL CYSTOTOMY.\*

**Its Comparative Superiority Over Other Methods of Lithotomy; Its Technical Facilities, etc.**

BY LOUIS BAUER, M.R.C.S., M.D. (ENG.).

*English Professor of Surgery in the St. Louis College of Physicians and Surgeons, etc.*

In passing my State examination in the year 1838, in Prussia, the question of Lithotomy was assigned me for elaboration.

In the scientific and practical pursuit of this subject, and in closely comparing the different anatomical avenues leading to the bladder, I was forcibly struck by the directness and simplicity which the line through the rectum offered. I did not fail to place my impression in high relief in my essay, but I had no opportunity to follow the subject into practical channels.

During the ensuing years I found no occasion to avail myself practically of the information then acquired, because the population was singularly free from difficulties of this kind. In fact, not before I had transmigrated to this country did I find a suitable opportunity.

It was when a resident of Brooklyn, N. Y., that I entered upon a scientific course of investigation, so as to meet all exigencies which the rectal cystotomy might possibly entail. My late friend, J. Marion Sims, of New York, took a lively interest in my undertaking, more particularly since I had decided to employ the silver wire suture in

closing the wound, and he therefore advanced my efforts to the best of his ability.

The points to be fully cleared up, as they would naturally present themselves to the performance of such an operation, were about as follows:

1. Could the field of operation, the trigonum, be rendered fully accessible to the light, to the eye, and to the touch, and by what means?

2. Can the recto-vesical septum be trans-fixed without incurring the danger of injuring the peritoneum, uterus, and seminal vesicle?

3. To what extent may the elasticity of the bladder be depended on for the extraction of larger calculi through a small wound?

4. Are there any, and what technical difficulties inclosing the wound?

5. Are there conditions which possibly will interfere with the first intention of the wound and eventually lead to urinary fistula?

*ad 1.* In distending the bladder by injected and retained liquids the organ enlarges in every direction. It can be felt above the pubic symphysis, and can be reached as well by the index finger introduced in the anus. When a pressure is applied upon the vertex, the trigonum can be brought in close proximity to the anus, which at the same time increases the tension to the bladder below. When so held in position, if Sims' speculum be introduced into the rectum, the field of operation is completely illumined and rendered of easy access. In patients afflicted with calculus in the bladder, the sphincter is greatly relaxed and frequently allows a part of the rectum to protrude. This condition is brought about by the frequent obstruction, and the effort of the patient to expel the urine. Under such circumstances

\* Read before the Mississippi Valley Medical Association, September, 1889.

tenesmus is superadded, and the latter leads to the condition of the sphincter to which I have referred. But if spastic contraction should prevail the subcutaneous division might be resorted to without prejudice to the patient. Thus from this side no difficulties could possibly be presented.

*ad 2.* The investigation of this point discloses to us the fact that in boys and in negroes the peritoneum descends more deeply into the pelvic cavity, and so closely to the prostate gland as to preclude the operation. In adults, however, of the Caucasian and Semitic races, the peritoneum leaves, in the average, one and three quarters of an inch of the trigonum free from peritoneal covering, consequently space enough for an incision to extract almost any calculus of not excessive magnitude. A morbid enlargement of the prostate gland alone could interfere. On two different occasions we were able to enter the bladder where such enlargement existed without any injury to the peritoneum.

*ad 3.* Upon three different dead bodies I performed the high operation, and inserted pebbles of different sizes, and then closed the wound hermetically. They were subsequently drawn out of the injected bladder through an opening in the septum, not quite half an inch thick. I found the elasticity sufficient to have even passed a larger pebble than those inserted. From this side there are no difficulties offered.

*ad 4.* In drawing the prostate gland toward the anus by a double hook inserted at its base, the wound was rendered easy of access, and could be closed without the slightest inconvenience; the insertion of a blunt hook into the lower angle of the wound facilitated the closure still more.

*ad 5.* Copious injections into the bladder through a catheter, combined with pressure upon the vertex, opened the wound very freely, and allowed the liquid to escape without entering the tissues.

Thus all our investigations returned satisfactory results, commending the practicability of the operation upon the living, and we decided to put it at once to a practical test upon the patient, Titus.

According to the plan so matured, I performed the operation upon several patients with all the ease and comfort possible.

1. In order to secure a proper position, I did not administer an anesthetic, and the patients assured me that they had not experienced the slightest sensation from the knife passing the septum. They first felt the finger when introduced into the bladder.

2. In the first case (Titus) Sims' lateral position was preferred; in the others we placed the patients upon knee and elbow, which offered some greater facilities for closing the wound, but rendered the catch of the stone more tedious.

In future I should prefer the Sims' position until the calculus was extracted, and then the patient should be placed upon knee and elbow.

In reference to the balance of the operation I followed the plan exactly as previously delineated. The suture was applied in the case of Titus by Dr. Sims, who performed his part with the ease, delicacy, and success for which his eminent skill and experience qualified him.

The operations were all performed in the presence of a number of eminent practitioners and surgeons, who expressed themselves elated with the new method and its obvious efficacy.

In the case of Titus the sutures were removed on the seventh day, when the wound was found hermetically closed by first intention. From the third day onward he passed his urine by the natural channel. He was discharged, cured, on the eighth day, and introduced by me to the late venerable Valentine Mott, who likewise expressed his appreciation of the new method.

In due course of time these cases were published in American journals, and the first likewise in German (*Archiv für Clinische Chirurgie*, Berlin), and I had thus discharged an agreeable duty to my profession.

I would have rested there with my efforts, leaving to my contemporaries in surgery the decision to adopt or to ignore the new plan, had I not found out that it had not been sufficiently placed under the cognizance

of the profession. And it is for this reason that I again call upon the attention of my professional brethren.

In reality the first operation of this kind was performed many years ago by Dr. Sleigh, then surgeon of the great London prison, Newgate. One of the prisoners under his charge suffered from a stone in his bladder. The calculus lodged in a diverticulum of the trigonum, and protruded to such an extent into the rectum that it could be readily felt, seen, and rendered accessible. He divided the septum and drew the stone out. Whether he sutured the wound, I could not ascertain; the patient recovered.

Almost the exact and same condition of a patient was presented to the late Professor Roser, of Tübingen. Instead of copying the surgical action of Sleigh, or performing the recto-cystotomy according to the details set forth by myself, to which the condition of the patient certainly invited, he preferred the high operation, and encountered certainly more difficulties than implied by my plan. I can not find any other explanation for this singular action of Roser, than the probability that Sleigh's precedent and my plan had never caught his eye.

In most works on surgery, published during the last ten years, I have found either no reference at all to my plan, or only mention of Sanson's operation, which, in my opinion, is not recto-cystotomy at all, but much more a perineo-cystotomy. All the objections raised very properly apply to Sanson's method, but not to mine.

I have successfully made, and seen many operations performed in my presence, and by comparison I have come to the following estimate of them:

(a) All the complications and accidents which may possibly happen pertain to the other methods of lithotomy in a higher degree than to my method.

A bungling performance would be just as dangerous in one as in another. Thus, Dr. Loebker mentions in his most excellent and admirable work on operative surgery, that one surgeon had injured the peritoneum in the act of puncturing the trigonum in the

case of retention of urine, which seems to me an utter impossibility to any one who understands the anatomy of the locality. Of course, if a man is incapable of making a straight vertical incision, he ought to abstain from surgical enterprises of this sort.

So far as my preparatory investigations and my own performance of recto-cystotomy are concerned, I can not recognize any danger at all, provided the proper indications and contra-indications are duly weighed.

I find in the annual report of the surgical clinic of Professor Albert, of Vienna, 1889, among the interesting subjects mentioned, a rupture of the bladder in a young man of twenty-five years, in whom litholapaxy had been practiced. Such an accident has never happened in my cases upon whom I performed lithotomy *per rectum*.

However, I hope the excellent operation of Bigelow is not doomed to the mausoleum of the Montechi and Capuletti on that account.

(b) The lateral operation has two very grave objections which do not apply to my method either.

1. The passage through the neck of the bladder, according to Gray, can not exceed one inch. Through such an aperture but a comparatively small stone can be withdrawn, and any larger stones require additional crushing.

The incision into the prostata is left to the care of nature; occasionally it does not completely close, and urinary fistula is the consequence. Infiltration into the connective tissue of the pelvic cavity, dangerous rents, and fatal termination are not so very rare occurrences. More or less the same objection holds good for the median operation, and need not therefore be specified.

The supra-pubic operation offers decided advantages over the two former ones—first, more ready access to the bladder, the removal of the calculus through an elastic portion of the bladder walls admits of the extraction of a considerably larger stone. But infiltration is much more often observed, and one of the greatest objections is the fact that as yet no suture has been successfully applied.

Of course the high operation is indispen-  
sably necessary for the removal of tumors  
of the bladder, which can not be claimed  
for my method.

There are, likewise, some contra-indica-  
tions pertaining to mine from which the  
high operation is free. But where the con-  
ditions are even, recto-cystotomy ought to  
be preferred, being infinitely safer, more re-  
liable and simple than even the high oper-  
ation.

### THE ACCOCHEUR AND HIS FORCEPS.\*

BY ALGERNON S. BAMES, M. D.

*Professor of Obstetrics and Diseases of Women and Infants in  
St. Louis College.*

My object in selecting the chief subject  
of my paper was not that I expected to be  
able to give any remarkably new points, as  
the ground has been gone over and over. I  
only hoped I might influence some benighted  
brother who objects to the frequent use of  
the obstetric forceps, from one cause or an-  
other, to thoroughly investigate the subject  
and convince himself of his erroneous ideas.

When without experience we are too fre-  
quently influenced in our opinions by arti-  
cles in journals, or remarks made by those  
in whose opinions we have confidence; or it  
may be our medical education has been more  
theoretical than practical; that we have not  
been taught to differentiate between igno-  
norant meddlesomeness, criminal neglect,  
and scientific assistance. May it not be  
possible that we dislike that branch of med-  
icine, or are not dexterous with instruments,  
or our slight personal experience has not  
been flattering either to forceps or user. It  
may be that our selection of forceps has not  
been good, or judgment of forceps cases;  
the surroundings of patient may have been  
bad, or improper remedies used, bad nurs-  
ing after use, and many other things that  
go to influence the mind. May these not  
account for our opinions?

If there is one subject or branch of medi-  
cine that should be of more interest than an-  
other to the profession and public, it is ob-

stetrics. The fact that the lives of both  
mother and child are greatly dependent  
upon the views held by the modern obstet-  
rician should be sufficient to make that in-  
terest perfectly legitimate and worthy of  
the greatest minds in the profession. This  
interest should necessarily grow in propor-  
tion to the possibilities of the accoucheur to  
render proper assistance to the lying-in  
woman, when needed, whereby her suffering,  
both mental and physical, may be assuaged,  
and even death of the mother or child pre-  
vented. That such assistance is needed at  
times, is beyond doubt. This being true,  
how necessary it is that the accoucheur  
should take rank as far above the every-day  
midwife in knowledge and ability as the  
master mechanic outranks his apprentice.

The responsibility that rests upon the ac-  
coucheur is certainly unappreciated by both  
members of the profession and the public.  
I am positive the accoucheur himself fre-  
quently does not fully comprehend his high  
calling and responsibility as he should. This  
is probably due to the very erroneous idea  
that exists to a considerable extent, that be-  
cause pregnancy and parturition are consid-  
ered physiological, there is little, if any,  
necessity for the rendering of assistance on  
the part of the medical attendant.

It is certainly sad, and no less strange,  
that medical men of known ability can hold  
such an opinion in the face of every-day oc-  
currences in obstetrical practice, where dys-  
tocia, and even death of both mother and  
child are forcing recognition at the hands of  
the scientific accoucheur. I am sure, if I  
had the time, I could convince any reason-  
able man that it is as unreasonable to sup-  
pose that nature deals with pregnancy and  
parturition differently from other subjects  
as to believe that she will not permit any of  
her laws to be broken or interfered with.

If there was no such thing as free agency,  
and our environments were always the same,  
with nature controlling every thing per-  
fectly, then we might trust her to do all  
things well. We would be free of all re-  
sponsibility, and would only *need instinct* to  
to govern us. And right here is where the

\* Read before the Mississippi Valley Medical Society, Sep-  
tember, 1889.

difference lies between responsible and irresponsible beings.

Nature is complex in character, doing the very best under the circumstances that exist. (Circumstances frequently interfere with her work, as we all know.) Nature tries to be regular in the performance of her work, but frequently needs the assistance of man's intellect to carry it out. It is not intended she should act independently of man at all times; she works for the benefit of man and is to be used by him for his benefit, but not to interfere with art and science, but going hand in hand furnishes us with material and means that can and should be utilized. But she is thwarted and misunderstood when some men, and most of women, attempt to practice midwifery, and there are penalties that accompany these mistakes—cause and effect. Seed planted in poor soil will not bring forth an hundred fold. The surgeon does not depend upon nature to correct deformities, neither should we expect her to correct morbid or abnormal conditions occurring with parturition. But we should ever be ready and competent to utilize the means and remedies that can be applied to the advantage of our patient scientifically. We should be able to substitute science and judgment for nature and instinct, and deliver the woman when necessary.

Educate nature and instinct and we have science, art, and ability (not meddlesomeness), which will enable us to not alone assist nature, but even do her work successfully.

The accoucheur who has to depend upon nature will soon tire, and wish he had selected some other calling, and so will his patient. In fact, you can see the bad results of that mischievous belief (that nature will and should do the work if left alone) in the practice of many physicians when attending cases of confinement, to such an extent that they feel their inability when called upon to render assistance, and are necessitated to send for some thoroughly posted brother to deliver the patient, and he unintentionally secures thereafter, not alone the golden egg, but the goose. The public can recognize talent at times.

The accoucheur's responsibilities are great, and so also his resources. Therefore, having the lives of mothers and their offsprings in his hands, he should certainly be expected to have a thorough knowledge, with sufficient ability to attend the cases that fall to his lot. Where we lack knowledge we are greatly handicapped, and will necessarily have circumscribed ideas, as it makes men superstitious, skeptical, and narrow-minded, jumping at conclusions without investigation, and necessarily dependent upon nature to do our work. As we feel our inability to render one iota of assistance that will be beneficial, we will sit by the bedside of our patient while she drifts toward the breakers, and we cry, let nature do her work, as this is a physiological act and must not be interfered with.

These are the men who are ever ready to condemn those who have the knowledge and ability, and dare to use them. The accoucheur can not afford to be embarrassed by prejudices, whether hereditary or acquired through education or association, as they are the great enemies to progress—preventing investigation, warping our opinion to suit them, as well as preventing our securing the benefit to be derived from the experience and research of others.

The practice of obstetrics is progressive, and necessitates continuous application and study to keep up with the times, or you drift back. He who does not apply himself will soon become antiquated, and in need of Brown Séquard's Elixir.

The accoucheur holds the most sacred and responsible position in society that is known. His influence to do good or harm is beyond measure. He is admitted within the most sacred precincts of the household, and is the custodian of the most valuable family secrets. It is he who frequently has to do with the prospective or real existence of one or more of the family, and often decides whether one or both shall have an existence. This being true, how necessary it is he should have prerequisites to fit him for this high position. He should certainly be a moral man, with love for his pro-

fession, and ambition to do good; kind, agreeable, and sympathetic. Firmness is a necessity against imposition and meddling, and insures the carrying out of orders in the after-treatment which will help greatly toward good results. Good judgment and quick perceptive powers will bear good fruits. He should be careful in making a diagnosis or prognosis, cautious in making examinations for the purpose of discovering the presentation or position of fetus, also condition of maternal parts. Honesty should be one of his chief corner-stones, then he could not be influenced in either judgment, opinion, or action by a pecuniary interest. I sometimes wonder if it is possible that revenue plays any part in the shaping of our acts or opinions.

There are temptations held out even to physicians in these days. When it has been proved that "cleanliness is next to godliness," it will behoove him to be cleanly in person and dress, demanding it also from all attendants in the treatment of patients as well as the patient herself. There are many other requisites which go to make up the scientific, practical accoucheur. As my time is limited I will only mention one other, and that is a thoroughly practical medical and obstetrical education, which is a *sine qua non*.

On entering upon the subject of obstetric forceps it is not my intention to go into their history, as that is well known to most of those present, besides it is to be found in most of the text-books, and is of little interest, comparatively speaking, outside of the fact that their origin sprang from a need that had been long felt.

It is not my intention to entertain or detain you with tables of statistics, as no one will probably deny what I could prove by them. It is my purpose to make a few statements which will need no statistics to prove.

The first is, that forceps have been in use for these many years, and have been a bone for contention ever since their first appearance, and will likely continue so until a higher state of practical medical education

places them just where they belong, as a means whereby a woman can and should be assisted or delivered without dissent.

The obstetric forceps are passive, but philosophical in action, but not automatic, therefore not responsible for the good or harm done by them, but dependent upon their backing, and, like the surgeon's knife, they have a work to perform and are not to be used as a substitute for any thing, as they have no alternates. The accoucheur should use them as hands for the purpose of adjusting and assisting nature in delivering the woman, and if necessary to extract the child. They differ from all other extraneous means used for the purpose of delivery, in that they are perfectly under the control of the accoucheur, and place the child there also.

There can be no possible doubt as to their efficiency and necessity, as they have stood the test of years and all the adverse criticism that could well have been heaped upon them, and still have grown in favor as their work has been better performed and understood. And when they are properly constructed and correctly used they have never failed to do good service, and he who does not use them in his practice will risk the lives of both mother and child, besides entailing unnecessary suffering on the mother.

After more than thirty-five years of active practice, and the delivery of more than 4,500 women in private practice, and a thorough examination of all the means that are used, I have come to the following conclusions: (1) That the great desideratum is the prophylactic and not remedial treatment, and that the use of the obstetrical forceps is frequently a necessity for that purpose, and that they should be used much more frequently than they are for the benefit of both mother and child. (2) That we have no right to condemn them because of their abuse by uneducated heads and hands, but should demand a more thorough knowledge of them by the profession, thereby bringing the physician to the proper knowledge, that he may use them scientifically. And just here I take

pleasure in recommending a small book that should be owned and studied by every physician who is not an expert in the use and application of the forceps. I refer to "How to Use the Forceps," by Prof. Henry G. Landis, of Columbus, Ohio.

The same excuse for not using the forceps can be applied to the surgeon's knife, and is neither legitimate nor philosophical in this age, when the chances for obtaining the knowledge are so good. Besides, it is this kind of argument that gives men excuses for not obtaining the necessary education upon the subject; and the time will come when it will be demanded by the courts of justice.

Tedious or protracted labors are acknowledged to be bad for both mother and child. Prof. A. F. A. King, after enumerating the particular dangers accompanying and following tedious labors, says every case of actual or impending tedious labor should excite apprehension for the woman's safety, increasing in degree according to the extent to which the symptoms have progressed and the estimated difficulty of prompt delivery. With timely assistance safety may often be assured, while delay may render recovery impossible. There is a great difference in obstetric forceps, and the danger of them is dependent upon their form of construction as well as want of knowledge on the part of the user. They should be strong—not slight, sharp, or springy—without too much pelvic curve, edges dull, wide fenestra. An accoucheur should be supplied with several pairs—at least two, a long and a short pair. A. H. Leslie, of St. Louis, has had several pairs made for me, which I take pleasure in recommending as just the kind to use.

A forceps case is a forceps case, not to be treated in any other way for want of knowledge on the part of the accoucheur. The onus that rests on the forceps does not belong to them, but belongs to what I call meddling, some or misunderstood midwifery, that burdens and complicates a majority of cases of dystocia, under the guise of scientific and humane treatment.

I mean the scientific treatment of using antiseptics before and after confinement, in the washing out of the vagina and uterus, which is neither philosophical, beneficial, nor necessary, but both meddling and harmful, as nature has made provision against sepsis in the shape of the lochia which protect the parts perfectly for at least three days after delivery, when every part of the reproductive tract should be in a physiological condition, and will be if the case has been properly treated.

Ergot has no proper place in childbirth. I agree with Prof. Landis, who says it is uncertain in action, and when it does act it causes tonic contraction of the uterus and an unremitting effort to expel the child. And, if this takes place before the os is dilated, laceration of the cervix may occur; if the head is large, rupture of the womb may occur. In any event the placental circulation will be continuously compressed and the child in danger of asphyxia. Ergot should never be given before the birth of the child, and from its uncertainty should never be depended upon in the third stage. It is not controllable, and there are better remedies for the same purpose.

Anesthetics are seldom admissible, and never so as a placebo, nor substitute for other remedies. Chloral and opium may be administered, if necessary, in small doses frequently repeated, for the purpose of allaying contraction caused by irritation, and for relaxing rigid muscles. Ergot and anesthetics complicate labor, even when normal, as it is well known, and they are the cause in many cases of puerperal troubles where the forceps receive the blame.

I never use ergot in childbirth, and but very rarely administer chloroform, and never wash the uterus out, but always see it is perfectly clear of all portions of placenta, membranes, and clots, insist strictly on sterility and cleanliness, use the forceps frequently, but only in forceps cases.

Do not permit tedious labors when possible to prevent them, which is in a very great majority of cases.

I will now close this address by a death-

ing what I consider to be a forceps case, taking it for granted the accoucheur is thoroughly up in his branch, and is supplied with the proper kind of forceps. They should be used whenever the case has been a long enough time in true labor to satisfy the medical attendant that it is not sufficiently progressive, of which he must be the judge, maternal parts being in a proper condition, and the fetus of normal or corresponding size to the maternal pelvis, and there are symptoms of any kind to indicate a want on the part of nature to do her work, or when there is a necessity for slight compression, for the purpose of causing the head to mold, or for the purpose of slightly changing the position the child occupies to itself, or when it is considered best for the woman to be delivered at once. All of which the accoucheur in attendance must be the judge; always bearing in mind your responsibility, and what should be expected of you as a scientific physician by the profession and public.

With this treatment I have been so successful that I neither lose lying-in women by death, nor do they have puerperal fever or sepsis. So I take pleasure in recommending it to those of you who have not met with such success.

### NASAL DIFFERENTIATION.\*

BY GREEN V. WOOLEN, M. D.

The wonderful progress which has been made in medical science in recent years has rendered it possible to be specific in many ways hitherto undreamed of by our forefathers. In none of its departments is this more manifest than in that relating to the upper respiratory apparatus.

That we have reached the final goal no one acquainted with the subject will conclude. It is with a view to assist to this ultimate perfection that this contribution is made.

Nowhere is a full and complete appreciation of the anatomy and physiology of the

parts so essential to a correct interpretation of the pathological conditions as in the nose, and already much has been written in its more perfect elucidation.

Criticisms have been offered to these efforts as a refinement in medicine not warranted by the facts, and, instead of shrinking from such, it is the purpose of this paper to particularize more specifically than is the custom of our authors.

There is a somewhat general agreement that the anterior and posterior regions of the nasal cavities are the seats of special morbid products which give rise to reflexes, of which hay-fever and asthma are the most notable illustrations, while some would locate the genesis of hay-fever in the anterior and asthma in the posterior regions.

I would be classed among the latter most distinctly from persistent and unprejudiced observation. This theory is first established by the fact that the two regions are innervated from very different sources. The former or anterior regions receive their nerve supply from the nasal branches of the ophthalmic or first division of the fifth pair of cranial nerves, while the latter or posterior regions are supplied from the descending branches of the sphenopalatine or Meckel's ganglions, both supplies coming immediately from different large ganglia. It is true that the latter or sphenopalatine ganglia and their distributions are regarded as portions of the fifth pair of cranial nerves, and that both the Gasserian and Meckel's ganglia are supplied with branches of the sympathetic coming from the carotid plexus, indicating that impulses coming through them would be reflexed in the same direction, but physiologically and pathologically we find it is not so. The physiological reflex known as sneezing can only be secured by irritation of the anterior nasal region, supplied by the nasal branches of the fifth; whereas, that known as coughing can only be secured, so far as related to the nasal cavity, by irritation of the posterior region, or that supplied by the sphenopalatine nerves, facts which writers do not insist sufficiently upon, but which are familiar to those who

\*Read before the Mississippi Valley Medical Society, September, 1889.

frequently manipulate these parts in surgical performances.

Then, again, no amount of irritation of the anterior nasal chambers will provoke an attack of asthma unless it first arouse irritation of the posterior regions. This is notably witnessed in every hay-fever subject whose asthma is *always* preceded by the anterior nasal irritation or so-called hay-fever, frequently days and not infrequently weeks.

It is not the purpose of the writer, and indeed we may not be able to trace these reflexes which arise from these regions, supplied by these main sources of nerve distribution, as definitely as we could wish, but we know that fequent sympathetic nerve reinforcements occur not only at the main ganglia, but by union of nerve filaments, which admits of possibilities of communication other than by the main line of sensory nerve supply. Enough is known, however, to warrant the belief that distinct morbid manifestations are to be found in these particular regions.

We may not seem fanciful if we regard the nasal nerves as the monitors of the nasal cavities, while the sphenopalatine and their coadjutors perform a like office for the larynx and esophagus. True, they both command the motor apparatus of respiration, but certainly in a modified way. Whether we regard the exciting causes of hay-fever as one or many, its genesis in a pathological sense is found in the area supplied by the nasal nerves, and the process is often confined in its entire expression to this locality. And to individualize more specifically, I would say that hypertrophy of the anterior tips of the inferior turbinates with a peculiar hyperesthesia is the essential local factor of the disease, which, especially during the attacks, is distinguishable by a peculiar pale whitish color, not unlike washed veal, a fact not mentioned by any authority that I know of.

Likewise, whether we regard asthma as due to a spasmodic contraction of the small circular muscular fibers of the bronchial tubes, or to paralysis of the vaso-motor

nerves regulating the caliber of the blood-vessels of the bronchial mucous membrane, it matters not as to the pathological genesis, as this is always found in the post-nasal region and its environments, and is often disassociated with any complications.

Again, to be specific, I would locate the essential pathological factor of asthma to hypertrophy of the posterior tips of the inferior turbinates, and occasionally of the middle ones, which are probably equally as hyperesthetic as the anteriors in hay fever, but not so easily demonstrated. These invariably, according to my observation, must touch the septum opposite, or, what is apt to be most misleading, curl up on themselves and touch the outer walls of the nares, and thus secure "pressure irritation," and resulting in reflex distress.

These local pathological conditions are frequently confined to one side of the nasal cavity, and yet beget all of the phenomena peculiar to the affection, whether hay-fever or asthma.

Of course it is understood all cases having hypertrophy of these parts do not have these maladies. Only those with the peculiar predisposing systemic dyscrasia and local hyperesthetic nature respond to the exciting causes.

I am not unmindful of the fact that cases of asthma have been reported as a result of nasal polypi, elongated uvula, hypertrophic tonsils, etc., but it should be remembered that these are conditions associated with hypertrophic disease, and also that the relief of asthma is often delusive, and that cures are not always what they seem.

I would not wish to appear discourteous in this statement, but would simply state that, helpful as the removal of such excrescences are, they have never been sufficient alone in my experience, and that treatment based upon the theory which has formed the basis of this paper, if sufficiently radical, has not failed to be very satisfactory.

Time and purpose will not allow me to go into details, but I am persuaded that failures are attributable to a want of thoroughness of extermination of these disturbing factors.

It is not always easy of accomplishment, because of difficulties associated with the surgical process and prejudices of patients. I would as soon think of temporizing with malignant disease, hoping that *vis medicatrix nature* would accomplish what I had failed to eradicate, as to expect complete and final results without exterminating all sources of exciting causes in these localities.

A third region of the nares furnishing special manifestations of hypertrophic disease equally as interesting as those noticed is to be found at the anterior tips of the middle turbinates. Dr. Edward Woakes, of London, was the first to give special attention to this, and called it ethmoiditis, claiming that it was essentially a necrosing process, and gives but little attention to it in its earlier stages, dealing more with it in its later stages when associated with polypus, insisting that necrosis is a necessary pathological basis to the process. He traces reflexes from here, which, in my mind, clearly proceed from other regions which are almost universally involved, as indicated in the early part of this paper.

From a careful study under his personal supervision, and subsequent extended attention to this trouble, I am persuaded that it pursues the course which he describes much less in this country than in England, but that the early or non-necrosing stage is more persistent, and gives rise to a class of symptoms not necessarily present in the later stages.

It will be remembered that the nasal nerves enter the nasal cavities in front and above the anterior tips of the middle turbinates, dividing into the external and internal branches, after having passed from the orbits to the cranial cavity, with three branches given off in the orbits, the ganglionic, ciliary, and infra-trachlear.

Now it will be found that one of the commonest results of hypertrophic disease of the nares is enlargement of these particular parts, that is, anterior tips, which, from the restricted space of this portion of the nares and proximity of these nasal nerves, results in injurious pressure of these nerves.

Reasoning *à priori* one would expect orbital and supra-orbital neuralgias, with disturbance of cerebration, and clinically we find such to be the fact. Oftentimes this is limited to one side only—a veritable hemiparasia (migraine)—and is invariably associated with hypertrophy and pressure of this side, the pressure directly from its own size or from deflected septum.

Furthermore, removal of the hypertrophy and pressure as certainly removes the neuralgias and cerebral symptoms, although not always at once. The explanation of this is, that “it is by large orifices at the upper and front part of the middle meati that the anterior ethmoidal cells, and through them the frontal sinuses communicate with the nares,” and that enlargement and overhanging of these turbinate tips would greatly obstruct this exit, resulting in more or less disease of these cavities, which subsequent time and treatment must efface after removal of the obstructing mass.

That much of our “sick-headaches” and “nervous headaches” are the result of this “pressure irritation” and consequent cerebral distress, with stomach only affected sympathetically, I believe, as it has disappeared upon removal of the pressure.

When Dr. Lefferts, of New York, called attention to “pressure irritation” and “defective drainage” as chief factors in perpetuating nasal disease, he cleared away a great amount of fog and mystification.

Situated near the base of the brain, as this trouble is, one can easily understand how such grave troubles as migraine, orbital and supra-orbital neuralgias, syncope, epileptoid seizure, melancholia, etc., can arise. The nerve and blood supply of parts and organs are so inseparable that functions are sure to suffer when either are greatly disturbed.

INDIANAPOLIS.

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CHEAP—IF GOOD.—Russia has fixed doctors' charges. Physicians making \$450 per year get 45 cents per visit; others 25 cents. In country towns 10 cents is the usual charge.

## THE PRINCIPLES THAT SHOULD GUIDE US IN THE RATIONAL TREATMENT OF GONORRHEA.\*

BY BRANSFORD LEWIS, M.D.

If we were to reckon progress in medicine by stages, we could select no more apt a term for designating the present one than that of the Stage of Bacteriology. Bacteriology has assumed such an important rôle in all that relates to medicine or surgery that our attention is drawn to it in the consideration of almost every subject in medical or surgical science. And yet, dropping from this lofty plane of thought, which tempts us into the field of glittering generalities, and limiting ourselves to the more practical question at hand, let us inquire: *What has this all absorbing and comprehensive study and knowledge of bacteriology done for our assistance in the treatment of gonorrhœa? Has the hope of aborting, of quelling, of exterminating the disease by a treatment based on the discovery, study, and acquaintance with the life-history of that sturdy villain, the gonococcus, been realized? Have the methods of treatment thus brought into vogue accomplished the great wonders expected of them? Have they accomplished any thing more than the palliation, to a considerable extent, of the severity of the disease, of shortening somewhat the duration of its several stages, and of doing away with the old and barbarous forms of astringent, caustic, and stimulating injections? I believe that all those who have tried this or that new antiseptic, this or that "infallible germicide," not simply on two or three isolated cases in which beautiful results may have been attained, and which, by the way, were in all probability not gonorrhœa; I say, that all those who have tried such new antiseptic plans of treatment in a considerable number of cases are doubtless convinced that none are infallible, that all are subject to various influences, deleterious or favorable, that were met with in treating after the older prudent methods.*

Many beautiful and touching theories have

been constructed to explain how the gonococcus would quail with fear when in his revels he should detect from afar the fumes of death-dealing iodoform, brought into action by means of this or that preparation; or of how he would shrink with horror at the prospect of being literally boiled alive by hot injections; or washed out into the cold, cold world by the relentless flood of a prolonged irrigation; or of being crushed in spirit, body, and soul by the continuous presence of a medicated gelatine tampon; or dried up into an Egyptian mummy of a cocoon in the arid soil of a mildly astringent, antiseptic, non-irritating, magic-healing, absorbent powder! But experience with these agents would seem to indicate that the usual rule of the breeding of *one's* right by familiarity is not broken in this instance. Nay, more! that the festive gonococcus after a while appears to become sufficiently acclimated to enjoy his surroundings for a time at least.

And this, notwithstanding the fact that antiseptics do kill gonococci, and with great certainty and facility, when they are in culture fluids. But why not when they are in the urethra as well? For this reason: the gonococcus, in preparing himself for the conflict, does not foolishly remain where his foes can get at him with these various medicaments; he makes his landing and starts immediately for the woods, so to speak. He pushes on, by proliferation, between the epithelial cells, breaking through their connecting substance, and finally encases himself below its deepest layers, along on the basement membrane, and even sometimes within and between the interlacing fibers of this structure. Here he proliferates and disseminates to his heart's content.

This has all been repeatedly and absolutely proved by eminent investigators. Bumm has watched the invasion of the conjunctival tissues by the hordes of gonococci; has seen them penetrate to the connective-tissue layer, and has noted the strong obstruction offered by this tissue to their further progress. Not only this, but he has seen that the effect of astringents

\*Read before the Mississippi Valley Medical Association, September, 1889.

applied over the epithelial surface serves only to constrict and harden this covering, which then, indeed, forms a secure protection against the absorption or leaking through of any germicide or antiseptic which, embodied in the injection or what-not, has been applied to the mucous surface. Moreover, he has seen that the elimination of the cocci contained in this mesh-work of cells and fibers is brought about, not by the penetration of the germicides into the tissues, there to attack the organisms in their strongholds, as has been thought by some, but it is accomplished by a process of proliferation of the connective-tissue fibers into which gonococci are unable to penetrate, as intimated above. In the stage of improvement these fibers, incited by the irritation present, increase in number, push forward, driving before them the microbes toward the surface of the membrane, from which they are washed by the outgoing urine or killed by the germicides. When a sufficiently strong connective-tissue bulwark has been constructed, new epithelial cells begin to dot the denuded surface here and there. The cocci have by this time lost much of their vitality and are unable to break them down with the ease shown at the first onslaught. The conditions for resisting their inroads, too, are then more perfect. They lie simply along the surface or among the superficial cells.

So that the final process of cure depends not altogether on the extermination of the few remaining gonococci, but also, and perhaps more especially, on the closing of the tissues against their further invasion by the development of firm layers of this protecting barrier. And the inflammation then persisting may be interpreted as denoting the chronic irritation remaining after the severe disorganization wrought by the previous disease.

It is for these various reasons then that in the earlier stages, when the gonococci themselves are doing the damage, the efficacy of antiseptics, germicides, astringents, etc. is limited to the position which they now occupy.

In order to overcome these impediments and give access of the medicines to the ambushed cocci, an enthusiastic Frenchman has recently suggested that the epithelial coat of the mucous membrane be scraped off by a brush-swab, on the plan commonly used in cleaning a pistol barrel, after which the urethra is to be douched with a powerful antiseptic solution. This method is original, and ought to prove effective—in producing a stricture, if nothing else. It is certainly more energetic than any I should care to undertake.

I would therefore submit that efforts at aborting or killing a gonorrhea with strong medicines, antiseptic or otherwise, not only do not attain the desired end, but are ill-advised and liable to be followed by unfortunate sequelæ or complications; consequently treatment should be based on a plan having for its object the idea of carrying the disease through its various stages, as authors used to say, *tuto, cito et jucunde*, allowing the patient to experience as little discomfort, pain, and annoyance as possible, mollifying the inflammatory reaction and destroying, devitalizing, and discouraging the gonococci as much as our rather restricted powers will admit of, and hastening the healing process with all possible speed.

To accomplish these ends, having used various forms and modes of treatment, I have concluded that the one offering, with the general run of cases, the most advantages with the fewest objections, is that of giving in the first stage of the affection simply alkaline diluents and sedatives internally, making use of such adjuvants as dipping the penis in hot water, etc., and in the second and third stages giving injections of lanoline medicated with an absolutely unirritating antiseptic, to which may be added in the third stage a mildly astringent and stimulating antiseptic.

As a means of introducing the ointment, I have been using during the last six or seven months this hard-rubber application, which I present for your inspection. As you see, it consists of a catheter-like stem perforated at its end, which is inserted into

the urethra to the desired depth; a box to contain the ointment, and a piston which is screwed into the box, driving the ointment before it into the stem, and thence through the perforations into the urethra. When properly performed, an injection given with this instrument causes absolutely no pain or discomfort to the patient. But sometimes a sudden movement on his part will jog the stem against some tender spot and evoke an immediate and earnest protest. To obviate this, and to leave nothing undone that could in any way assist in avoiding irritation of any kind, I have had some vulcanized, soft-rubber stems constructed which answer the purpose very well. The square shape of the second (modified) box is of advantage in affording a securer hold on it. The stem need not be inserted as deep as its length will permit; the flexibility of the lanolin and elasticity of the urethral walls assure the spreading of the ointment over the inflamed area. (Messrs. Aloe & Co., of St. Louis, have kindly constructed the instruments for me.)

As to my reasons for preferring lanolin to other vehicles, I would say that with reference to the other vehicles, water, the most common, is itself, in its purest state, irritating, and unless it contain some local anesthetic will cause pain; powders or tablets, though dry and absorbent when first deposited, soon become moist and cake up, losing the properties for which they were chosen; gelatine bougies give pain at every movement of the body until they are liquefied; mucilages or emulsions present no advantages which are not possessed to a greater degree by lanolin, and—a point of great importance—all of them are lacking in staying qualities. With the first passage of urine cut they go, and in order to make their effect continuous they must be renewed several times a day, entailing frequent repetition of the trouble, pain, etc., experienced each time.

Lanolin presents none of these disadvantages: it is wholly unirritating—is even soothing to inflamed tissues. When introduced pure, even without any pacifying sedatives, it invariably causes a feeling of

relief and comfort to the patient who has been constantly reminded of his ailment by the teasing, harassing sensation incident to all cases of gonorrhea. As one patient remarked, the ease afforded allowed him to forget all about it for hours at a time, whereas before he began to receive the treatment it was never out of his mind while he was awake. I believe that the principal reason for this is that it keeps the inflamed surfaces apart, preventing their continuous friction and auto-irritation. Actual pain in the urethra is also mollified by it.

The oiliness of lanolin assures its adhesion to the canal walls even in spite of the flushing of the urethra by the stream of urine. It may be noticed floating on the urine of the second or third passage after the application. It is evident that in this respect, too, it surpasses all of the excipients named. An authority tells us that lanolin possesses antiseptic properties of no mean order.

I shall not take up more time in detailing its many advantages, which are almost self-evident.

As to the medicament employed, any remedy given in solution may be prescribed with equal propriety in lanolin. Of the various drugs which I have used I sum up my impressions as follows: Bichloride of mercury, even in minute quantities, is too painful or irritating, and frequently causes an increase in the pus formation; carbolic acid is also irritating but not painful; iodoform might be used were it less perniciously active in its odoriferousness. The zinc preparations are applicable to the later stages, in which they give material assistance toward shortening the windup. Resorcin would be a most admirable remedy were it not a most aggravatingly unstable drug. If administered after it has degenerated it will not be long ere the operator has cause to regret his efforts in the way of economy. Boric acid directly following the increasing stage of the affection seems to fulfill every indication—it is an antiseptic, a permittent, and yet has absolutely no irritating effect on the inflamed membrane. It is capable

of killing the gonococci that it reaches, and of preventing attacks from other microbes which give rise to the secondary or mixed infection of Bumm. And, by the way, the continuous presence of medicated lanolin forms a vigilant guard against this complication.

Agreeing then with the dictum of all authorities of the present day, that gonorrhea is a specific disease which can not be aborted after it is once fairly started, I conclude that (1) our treatment should not have for its object the futile idea of jugulating the disease in its early but established stages; (2) the endeavor to control its severity, to lighten in every possible way all of its disagreeable features, to shorten its course, and to ward off complications should be our guiding principles; and (3) no local agent does its share in fulfilling these indications more perfectly than does lanolin, medicated after the manner suggested.

ST. LOUIS, 1006 OLIVE STREET.

## Societies.

### MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

Meeting at Evansville, Ind., September 10, 11, and 12, 1889.

The Association began work at Evans' Hall at 11 o'clock the 10th inst. A short address by Dr. A. M. Owen, chairman of the Committee of Arrangements, was followed by the address of the president, Dr. G. J. Cook, of Indianapolis.

Nasal Differentiation was the first paper. It was read by Dr. G. V. Woolen, of Indianapolis. (See page 200.)

In the discussion that followed, Dr. Wm. Porter said that he believed in all that the author claimed in his paper. He thought, however, that he could narrate exceptions to his general results, as, for instance, he has seen asthmatic symptoms entirely relieved by the removal of obstructive excrescences.

Dr. D. S. Reynolds then discussed the paper technically at some length.

Dr. Lucas believes there are cases of

asthma produced by hypertrophies of the posterior nares, and therein differs from Dr. Reynolds. In many cases habit has much to do with the persistency of asthma even after the exciting causes have been removed, the disease in this respect resembling epilepsy.

Dr. Mathews, of Louisville, followed with a paper on A Simple Method of Treating Fistula in Ano.

He gives two methods; one can be used only in selected cases. He divided the sinus, scraped with scoop, sprinkled with iodoform, and united by superficial and deep sutures, and removed dressing on the tenth day. In four out of five cases he got union by first intention. Another method was by use of laminaria tent, followed by the urethrotome (dilating).

His modification of urethrotome for this purpose was shown. He calls his modification a fistulatome.

Dr. Murdock, of Pittsburgh, thinks that Dr. Mathews' selected cases are such as would be benefited by either the ligature or injection. The healing of fistulae does not take place because of the constant motion of the parts in defecation. Therefore it is highly desirable that the sphincter should be cut through either by the knife or ligation. He thinks in all operations on the anus the sphincter should be stretched if it is not necessary to cut it. He thinks that much benefit is derived from the use of laminaria tents.

Dr. Grant does not agree with Dr. Murdock's pathology. He also does not believe in ligature in fistula in ano.

Dr. Dalton approves of Mathews' plan of waiting ten days or thereabouts before applying the second dressing. Gerster waits only forty-eight hours before dressing again.

Dr. Dixon would not expect to cure a fistula with Mathews' instrument. He lays it open with the knife, scrapes out fistulous tracts, and dresses antiseptically. This is the only way he has any experience with.

Dr. Mathews, in conclusion, said he uses his instrument only in a few selected cases, and only when other means would be less

effective. He would prefer Dr. Dixon's plan in all cases, but the laity has a horror of the knife. Dr. Murdock forgets there are many fistulae and fistulous tracts which have no communication with the sphincter muscle at all. He selects for his operation such cases as are not interfered with by the sphincter muscle. He fears to rupture sphincter muscles by divulsion; here we should be very careful. He has seen incontinence of feces follow divulsion, especially in women.

Dr. Slaughter exhibited a case of cerebral surgery. A boy nine years old had fracture of skull from a kick; a space of three and a half inches of brain tissue was exposed. The accident occurred three and a half weeks ago. Temperature was never above normal, and pulse never above 99°. Wound healed by first intention. Appetite always good, and sleep undisturbed. The patient walked about and was freely examined by the physicians. Except pulsation and lack of bone substance, nothing abnormal could be noted.

The Accoucheur and his Forceps, by A. S. Barnes, of St. Louis, was next read. (See page 196.)

Dr. Wathen asked for statistics of mortality of children, etc. Answer: It ranges from  $\frac{1}{2}$  to 55 per cent.

#### DISCUSSION.

Dr. Wathen, of Louisville, was anxious to get per cent of mortality to children with forceps. How many are born dead? He has written to various places, but can not get statistics. He does not agree with reader in that the forceps can be used to mold the head when it fails to enter freely in the pelvic cavity.

Dr. Bell, of Indianapolis: Tedious labor is no indication for the use of forceps. There are two indications for its use, (1) Danger to the woman; (2) danger to the child. And of these the latter is the stronger indication.

Dr. Guhman, of St. Louis, read from an original paper some opinions pertinent to this subject. He gave statistics of 586 deliveries.

Dr. Murdock approves of the paper and of the use of forceps. He thinks the prac-

titioner does not apply them early enough or often enough. He goes further than the reader, and says that they should be used for the convenience of the physician when they are properly used, and many an obstetrician would be able to be at home in bed for hours if he applied forceps early and properly. He does not think that the obstetrician needs more than one pair of forceps.

Dr. Dixon, of Henderson, says that Dr. Barnes has had an average of 128 births a year for thirty five years, and hopes he will give us some idea of per cent of mortality in children. He agrees with the reader as to ergot, but not as to anesthetics.

Dr. Barnes, in conclusion, thinks that forceps should be applied when labor is unnecessarily long, and when labor is long and tedious it is dangerous not to use them. He read Dr. Guhman's statistics and thought them wonderful.

Dr. B. Merrill Ricketts read a paper on Plasto-cosmetics in Surgery of the Face.

In the discussion that followed, Dr. Bloom insisted upon the use of a galvanometer in electrolytic operation. He also believed that in many cases of epithelioma of the face caustics were to be preferred to the knife.

Dr. Rohé, of Baltimore, agreed with Dr. Bloom in these last two particulars. He exhibited photographs of patients upon whom he had operated, showing patient's condition before, and results after operation.

Antipyretics, Analgesics, and Sedatives, was read by Dr. I. N. Love, St. Louis.

#### DISCUSSION.

Dr. Mumford, of Princeton, Ky., warned the profession against the continuous use of antipyretics throughout a long illness.

Dr. Smythe, of Greencastle, Indiana: In fevers we may have death (1) from hyperpyrexia, and (2) we may have death from fatty parenchymatous degeneration as a secondary result of fever. Remarks that Dr. Love forgot to mention the cold water treatment. He objects to antifebrin and antipyrin if fever continues any length of time. Hence, in continued fevers he uses (as in typhoid) cold water and quinine.

Dr. Bransford Lewis, of St. Louis, is partial to phenacetin, which was not mentioned by the reader of the paper.

Dr. Hungate, of Kansas, adds his testimony to the value of acetanilide. He often gives it in whisky, combined with quinine and small doses of cocaine. It relieves headache wonderfully.

Dr. Linthicum, of Evansville, has used exalgine in five or six cases of neuralgia, two or three of intercostal neuralgia, and in four or five other cases, and he has never gotten any result at all.

Dr. Hollister, of Chicago, believes that a combination of acetanilide with quinine is good in those cases when there is a rapid rise of temperature. He thinks we should study the method of heat development in the body, and thus pave the way to influence it by anti-pyretic remedies.

Dr. Gray asks what effect *in epilepsy among children acetanilide has?* In his practice it is more valuable than the bromides.

Dr. Larrabee in pediatrics uses cold water to control pyrexia, and hence seldom other agents.

Dr. Love said, in conclusion, he believed in acetanilide in epilepsy among children. As to the ultimate effect on the mortality in typhoid fevers and allied conditions, he would state that it is his opinion that the drugs have great influence in diminishing it. He thinks the great blessing of those drugs is their tranquilizing effect.

Perineorrhaphy (the immediate operation), was read by Dr. S. E. Mumford, of Princeton.

#### DISCUSSION.

Dr. Worsham, of Evansville, thinks neglected ruptured perineum an inexcusable thing. The operation should be done at once or but a little time after labor. Does not think that every rent need be stitched. Some are so small (as through fourchette) as not to require it. When the perineal body is torn, then stitches are necessary.

Dr. Eastman said that where there is great edema of parts, or where there is acute albuminuria, it is better to postpone operation.

Dr. Bell thinks that perineum should be

examined both outside and inside. Would call attention to fact that perineum is often lacerated and yet the skin remains intact.

Dr. Smith asked whether it is always the head which ruptures the perineum, or if it is not more frequently the shoulder.

Dr. Wathen does not believe that there is any means to prevent laceration of perineum. The only possible reason for operation on small rents, not including muscles or fascia, is to close wound in order to avoid a source of septic invasion. Prefers kangaroo tendon to catgut for sutures, because catgut is absorbed too quickly.

When the Association met on Wednesday morning a succession of papers were read on Tuberculosis, the discussion occurring after the reading of the last paper. They were:

Prognosis in Pulmonary Diseases, W. C. Chapman, Toledo, Ohio.

Treatment of Pulmonary Phthisis, C. F. McGahan, Chattanooga, Tenn.

Differential Respiration, Frank C. Wilson, Louisville. This was illustrated by a belows contrivance for use in chest gymnastics.

On Contagiousness of Tuberculosis, William Porter, St. Louis.

Tubercular Peritonitis, with report of cases, Edwin Ricketts, Cincinnati.

Drs. Potter, Early, Woolen, Myers, Whiting, Reynolds, Eastman, Larrabee, Chapman, McGahan, Porter, and Ricketts discussed these papers. Several of these papers will appear in coming issues of this journal.

In the afternoon Dr. Shaw, of St. Louis, spoke on the suspension treatment in certain diseases of the spinal cord. He illustrated case by suspending two patients, and by a report of cases. The two patients suspended were sufferers from tabes dorsalis and paralysis agitans.

The paper was discussed by Drs. Dalton, Vance, Walker, Schelling, Ryan, and Lewis.

The grouping of papers was continued by one from Dr. Hugo O. Pantzer, of Indianapolis, another on Rupture of Ovarian Cyst, and Dr. A. M. Cartledge on Ovarian Tumor, with specimens. The tumor extirpated by the latter was unilocular and weighed one hun-

dred and twelve pounds, and is the largest on record.

H. H. Dalton, of St. Louis, read a paper on Sims' Method and its Failure, which excited the interest of all.

The last three papers were discussed as follows:

Dr. Eastman, of Indianapolis: I have reported a case where the contents of cyst weighed one hundred and thirty five pounds. It was not removed before death, but it was tapped three or four days *ante mortem*. He does not think the size has much to do with mortality. Adhesions are of more importance. He has done one hundred and nineteen laparotomies. In September, 1887, he tried Bergeron's H<sub>2</sub>S method to test permeability of the intestines, and finds it satisfactory. He uses it after abdomen has been opened to find rents.

Dr. Lydson stated that a case was reported in a journal a short time ago where the hydrogen test failed to show perforations, whereas the autopsy did disclose them.

Dr. Rickets: The majority of twisted pedicles are those arising from the left ovary. The tumor as it grows larger presses upon the transverse ascending and descending colon. When hard fecal matter passes up the ascending colon it turns the tumor on its axis, especially if the pedicle is long. He believes with Dalton that the hydrogen method does not always show the presence of perforation. Fecal (hard) matter often plugs up the rent and prevents escape of gas.

Dr. Vance does not believe in the gas method of Senn.

Dr. Steele in one case used gas, and none escaped. Nevertheless, when he opened the abdomen he found eleven holes. He operated five hours after the accident.

The next paper was on Chronic Tonsillitis, by E. Fletcher Ingals, Chicago.

It was discussed by Dr. Lewis, of Indianapolis, and Dr. William Porter, of St. Louis. The latter has had two cases where hemorrhage was excessive after extirpation of the tonsils, and consequently the dread of hemorrhage is always present with him. Referred to so-called scirrhous tonsil, wherein

blood supply is great, and operating upon which it is well to be prepared. Ordinarily there is little danger.

Rational Treatment of Gonorrhea, by Dr. Bransford Lewis, was read. (See this issue, page 203.)

Dr. Dalton says the practical effects of Lewis' were most gratifying in his hospital.

Drs. Bloom and Dixon discussed the paper and approved of it.

Dr. G. W. Ryan, of Cincinnati, read a paper on Orthopedics of Infantile Paralysis. (Will appear in an early issue.)

Dr. Vance indorses what Dr. Ryan says, and would only add that in some cases excision of bone or joints is often of benefit.

Dr. Bloom, of Louisville, reported two cases of amputation of the penis for carcinoma. He exhibited the specimens and demonstrated cancer by microscopical sections.

Drs. Ohmann, Dumesnil, Vance, and others took part in the discussion.

Dr. Bauer, of St. Louis, read a particularly interesting paper on Recto-vesical Cystotomy. His own experience was confined to three cases, all of whom recovered in less than two weeks.

Thursday morning, the last day of the convention, found fully half of the papers unread. The amount of material was so great, the subjects so interesting, and the time so limited that it was impossible to get over more ground. Dr. Larrabee's paper was perhaps the most interesting feature of the close of the meeting. It was on Infantile Therapeutics. It was ably discussed.

## Reviews and Bibliography.

**Inebriety:** its Etiology, Pathology, Treatment and Jurisprudence. By NORMAN KEED, M. D., F. L. S. Second edition. Pages, 471.

The author, for more than thirty years, has devoted his talents to the study of the nature and treatment of various forms of inebriety, having engaged in extensive courses of lectures on these subjects both in Europe and America.

The interest which the author takes in his subject, and the long attention he has

given it, naturally leads him to dwell on many points more than is likely to prove acceptable to the majority of readers. It must be said for him, however, that he exhibits greater prudence and wisdom than most advocates of total abstinence when dealing with the whisky question. There is in it nothing of that familiar tossing of the thunderbolts of the Almighty we are so much accustomed to hear, nor does he indulge in seemingly intentional misrepresentation.

His work consists of a statement of facts gathered from a wide field, and of just and fair deductions from them, and is, perhaps, the best work that one desiring information on the subject-matter could refer to. D. T. S.

**Lectures on Obstetric Nursing.** Delivered at the Training School for Nurses of the Philadelphia Hospital. By THEOPHILUS PARVIN, M. D., Professor of Obstetrics and Diseases of Women and Children at Jefferson Medical College, etc. Pages, 104. Philadelphia: P. Blakiston, Son & Co. 1889.

Obstetric nursing, while not poetry, will come easily within one of the definitions that have been given of poetry, viz., "fine thoughts in fine language." Besides setting forth attractively the facts a nurse should be familiar with, the author has enlarged upon the ethics of the calling and the etymology of the terms employed. Professor Parvin, it seems, could not but be scholarly in his style be his book big or little. The patient is to be congratulated who has the attention of a nurse capable of understanding and appreciating all the fine precepts contained in these lectures. D. T. S.

**The Year-Book of Treatment for 1889:** Being a critical review of the Practice of Medicine and Surgery during 1889. Pages, 344. Price, \$1.25. Philadelphia: Lea Brothers & Co. 1889.

In this work a complete account of all the more important advances made in the treatment of disease for the period covered by it is presented to the practitioner, accompanied by a review of points deemed most important by the several editors.

The medical literature of all countries has been placed under contribution, and the work deals with all the more important matters relating to treatment that have been published during the year ending September, 1889. Full references are given with each article, and a copious index is supplied, both of subjects and authors.

D. T. S.

**A Text-Book of Human Physiology,** including Histology and Microscopical Anatomy, with special reference to the Requirements of Practical Medicine. By DR. L. LANDOIS, Professor of Physiology and Director of the Physiological Institute, University of Greifswald. Third American, translated from the sixth German edition, with additions by William Stirling, M. D., Sc. D. With six hundred and ninety-two illustrations. Pages, 974. Philadelphia: P. Blakiston, Son & Co. 1889.

Of works suitable for the student of the average American college, where the whole course of medicine is usually gone over in two years, we have abundance, and these of high excellence. But for the student who would devote years to physiology, who would become familiar with all the minute facts and the interesting theories they justly give rise to, it is not too much to say there is but one text-book of human physiology, and that is the work under review. The arrangement of the matter in such a way that the most important part of each section is printed in larger type greatly facilitates its study to those who would not go into all the minutiae of any subject, and especially facilitates review; while in finer print, and with drawings, almost every subject is treated to exhaustion in so far as it may be so treated in the present state of knowledge.

D. T. S.

ON August 18th a Mexican boy was bitten by a mad wolf in the San Dias Mountains and died in great agony. He and his elder brother were playing near the house when the wolf attacked them, lacerating their faces and hands. It is feared the other boy will die.

## Correspondence.

## LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

A medical man who has returned from an expedition in the arctic regions proposes a new theory of snow-blindness. The geographical distribution of what is termed snow-blindness is said to follow closely the isothermal lines in the three continents bordering on the north pole—coming farther south in America and Asia than it does in Europe. The affection is also met with in very elevated regions, even under the tropics. In the northern climes the time of year in which snow-blindness is most frequent is the spring, though it may also be observed during the summer. According to the latest paper on the subject, it usually affects but one eye, and that eye is the one which has been most exposed to the direct rays of the sun, and it is upon this fact chiefly that the author bases his theory of snow-blindness. The regions in which the affection occurs are characterized by an intensely cold air and a low degree of moisture. As it is the humidity of the atmosphere that absorbs the heat of the sun's rays, they ought to exert a more intense action here than in lower latitudes, and that this is the case is rendered evident by the fact that the skin exposed to the sun suffers more from its action than in other regions; frequently a very painful dermatitis is thus set up by even a short exposure to the sun. Snow-blindness is due to the same cause (great dryness of the air and intensity of the solar rays), and the process in the two cases is the same, namely, hyperemia, and then exudation accompanied by an intense burning sensation. Erythema of the conjunctiva is the author's term for snow-blindness, and that it is primarily an affection of the conjunctiva rather than of the retina is shown, he thinks, by the fact that it is caused by irritation from the fine particles of snow during a "blizzard" as well as by the sun's rays. To prevent snow-blindness the Esquimaux use a disk of thin wood with a minute transverse slit in the center. Goggles made of moderately fine wire net-work without glass are recommended in place of the so-called "snow eyes" of the Esquimaux.

The late Surgeon General to the Government of Bombay has recently written on the time-honored subject of nightmares, which he is inclined to think must be dying out. The writer shows that nightmare is undoubtedly due to imperfect digestion, and with all the faults and follies of the present age people do not, as a rule, now play the pranks with their digestive organs that old-fashioned folk used to do. One does not now indulge inordinately in "chestnuts and sour wine," which an old medical work pronounces a common source of incubus. It is indeed "reported that the savages of Mount Atlas were dreamless, but if so," says Sir William Moore, "they are the only savages who could thus burst." In his experience, savage and semi-civilized men dream even more than the products of civilization. And the reason is evident. They fill their stomachs to repletion, and, like wild animals, sleep immediately afterward.

The rumor that perhaps the Queen, should she not soon recover from the rheumatic attacks from which she has suffered so much this year, might visit Strathpeffer, in Rosshire, has brought this hitherto little-known health resort into notice. The waters rank—taking the quantity of sulphureted hydrogen gas they contain—with the most important cold sulphur springs in England and on the Continent, being as strong as Meinberg and Baden, stronger than Harrogate, and three times as strong as Weilbach. They are stronger in cold than in hot weather, and are therefore as frequented in the autumn and winter as in the summer. The late Duchess of Sutherland, to whom the property belonged, spent large sums of money in developing the place and in building baths and hotels, adding materially to the value of the property.

Sir James Crichton Brown, in his address on Psychology, when speaking of the vulgar error of supposing that the pleasures of the imagination tend to insanity, said: "Now and again some erratic genius of highly-strung nervous temperament gives himself up to the pleasures of the imagination till he becomes intoxicated with them, and straggles over the boundary of sanity;" but he did not hesitate to say that for one case of insanity caused by

excess of imagination, there are a dozen caused by the want of it. The nature of mental disease, he thinks, is gravely misunderstood. The insane, he declared, are the least imaginative of beings; and visitors to asylums who invariably expect to find growths of morbid invention and belief, as invariably leave them disappointed. "As a rule," said Sir James, "the lunatic is as dull as a stone. He is the victim of a fixed idea, or his delusions pursue a treadmill round, or occur in groups so unvarying that if you have ascertained one of them you can predict all the rest." It is, in truth, not faculty run wild, but the absence of faculty; and the first thing to be done in trying to cure insanity was to invoke the aid of imagination, which, said Sir James C. Brown, seems to have a trophic influence on the brain. Wherever there was imagination there was vigorous function; where there was none, there was weakness. Hence this experienced specialist appeared to regard the growing indulgence in the reading of fiction with entire equanimity. It is profitable, he said, and hygienic, and so is the influence of picture-galleries, concerts, and musical performances. He finds that the appetite for fiction is most urgent in spring. In proof of this he said that in the Birmingham lending libraries the issue of novels reaches its maximum in March and its minimum in August.

Considerable alarm has been manifested in London during the past month on account of various rumors that have been circulated to the effect that typhoid fever had made its appearance in the West End, and that an epidemic of this terrible malady was to be feared. It appears that in all there were about twenty-one cases. The fever was limited to houses of the better class, including some of the largest houses of the neighborhood. Two facts in connection with the appearance of the epidemic are remarkable, one of them being that it took place almost entirely in the fashionable purlieu of Mayfair, and the other that no fresh cases have broken out since July 27th, two days after the commencement of the outbreak. It has been suggested that it was due to defective sanitary arrangements in the district, but Dr. Corfield, the sanitary medical

officer, who is now making careful inquiries into the matter, inclines to the belief that it was owing rather to some temporary cause which has apparently already ceased to operate. He has arrived at this conclusion from the uniformity in the date of the attacks, and from the fact that the sanitary arrangements of most of the houses where there are cases have been carefully carried out.

Among the persons described in Mr. Algen's book, "Englishmen in the French Revolution," is Dr. Rigby, the most remarkable event in whose life was his singular good fortune in having a piece of plate voted him by the Norwich Corporation because his wife gave birth to four infants at once. The infants died. It is not recorded whether the doctor gave back the piece of plate.

A special ward for lepers has been established at Dublin in the House of Industry. It is reported that there is *one* leper in it.

LONDON, ENG., August, 1889.

## Abstracts and Selections.

THE PRACTICAL VALUE OF THE OPERATIVE TREATMENT IN CONJUNCTIVITIS FOLLICULARIS (GRANULOSA).—When follicular inflammations of the conjunctiva once become installed in pauper schools, homes, barracks, or similar places where large numbers of inmates, especially children, are gathered together, they resist stubbornly the best directed efforts at eradication. The sources of contagion are endless, and in spite of frequent inspection of the eyes, rigid sequestration of the subjects of the disorder, and the exercise of great cleanliness, new-comers are attacked and the disease becomes endemic. Probably not the least common source of infection is the frequent relapses to which these forms of conjunctival inflammation are subject, during which muco-purulent secretion arises, highly contagious in character, and readily passed by means of contact, towels or utensils, from one case to the other. If, then, direct operative measures will yield results better than those attained by the standard local applications, especially results that tend to do away with the endemic character of this disease in crowded eleemosynary institutions, these should naturally recommend themselves to the exclusion of other procedures.

Vossius (*Therapeutische Monatsheft*, June

and July, 1889.) contributes some very interesting points bearing upon the question. In one poor-house during four or five years granular (follicular) conjunctivitis, in spite of the use on the part of the attending physicians of nitrate of silver, sulphate of zinc, and sulphate of copper, was not materially modified, and practically each child who was admitted to the institution became the subject of this form of conjunctival inflammation. After a time the children in a neighboring orphanage were beginning to be affected, and the endemic assumed dangerous proportions. An examination revealed forty-seven per cent of inmates afflicted with various types of the disorder, as follows: In eight children the upper and lower retrotarsal folds were thickly beset with follicles; in eleven children large groups of the same character were found, similar in appearance to Peyer's patches in the alimentary canal, in the formix of the conjunctival *cul-de-sac*; and in seventeen children the first symptoms of follicular (granular) conjunctivitis, namely, lachrymation, photophobia, injection of the conjunctiva, a feeling of sand in the eye, glueing together of the edges of the lids, and, upon inversion of these, on the retrotarsal folds the characteristic granulations in the conjunctiva were evident. Severe corneal complications were absent. The cause of the endemic in this place was, as is so often the case, due to direct contamination through the use of common utensils. In these cases, some with and some without either, the follicles were removed by means of forceps and Cowper's scissors, the depth and extent of the incision depending upon the character of the disease. After the operation, beside precautionary means to avoid extensive reaction, the local measures were continued, especially lotions of boric acid. Three months later an investigation revealed an entire absence of recurrence, and no new cases of follicular conjunctivitis had broken out; certainly a very satisfactory result.

On another occasion, among 300 scholars, 120 or 40 per cent were the subjects of follicular conjunctivitis, and stubbornly withstood the ordinary treatment. More than 100 children were operated upon without any serious complications, except in a few instances, where a sharp blenorrhoea of the conjunctiva occurred, but with the ultimate result at the end of the year of eradicating the epidemic, and preventing the appearance of any new cases.

Another school furnished an interesting

record of the march of this trouble. In 1886 there were only 27 cases of pronounced follicular conjunctivitis, and 53 examples of mild conjunctival catarrh; in April, 1887, there were 97 children with catarrh and 33 with granular disease of the conjunctiva; and, in May of the same year, 107 of the 1,051 scholars, that is, 10.18 per cent, were in need of vigorous procedures. Fifty-eight of the boys underwent operation, and by the end of the year the children were well. An interesting point in the etiology of this epidemic, as well as in other observations made by the author which we also have had the opportunity of noting ourselves, is the origin of these follicular inflammations during summer among children who frequent free baths, especially such as are unencumbered, and in which no due precautions as to cleanliness are taken. The usual source of infection in these instances is the employment of the same towel by many individuals.

We have quoted these observations of Vossius at some length, because they seem to us to emphasize most important points in the management and hygiene of homes and schools where poor children are gathered together. Absolute cleanliness—not merely as far as the outward skin is concerned, but in habit of life, and with the opportunity of using separate utensils, towels, bed clothes, and the like—isolation at once and promptly of such children as are afflicted, redoubled care, if the appearance of mucopurulent discharge is noted, are precautionary measures so evident that it is only necessary to mention them in order to see their importance. Finally, if Vossius, Schneller, Galezowski, and others are to be believed, and it seems quite rational that they should be, when the disorder has become established, it is better not to temporize with lotions, but at once, in suitable cases, to perform excision of the affected areas. Probably a sufficient number of cases has not as yet been thus treated to definitely settle the status of the operation, although Vossius' experience includes one thousand examples, but it is certainly true that other this method or the most vigorous antiseptic applications and aseptic precautions are measures that recommend themselves most forcibly.—*University Medical Magazine*.

#### MERCURY BINOCHIDE AS AN ANTISEPTIC.

Having read with much interest the paper of Woodhead, of Edinburgh, upon this subject, in which he calls attention to the results which he attained with this salt in some laboratory experiments devoted to

the determination of this question as to whether the biniodide, like the bichloride, forms an albuminate of mercury in the tissues, I asked a well-known druggist, Mr. Milton Campbell, of this city, who manufactures a large number of antiseptic tablets, to conduct a series of tests as to this question. Woodhead asserts that the biniodide does not form an albuminate; but the results reached on this side of the water are directly opposed to this statement, as will appear from the following results, sent me by Mr. Campbell. As I prepared the blood used in these tests and saw the results, I am ready to vouch for their accuracy if necessary. It should also be stated that the solution of the biniodide used was made after Woodhead's directions with iodide of potash.

The following results were reached:

1. Solution  $\text{HgI}_2 + \text{KI}$ , definite strength, when added to blood throws down a copious precipitate of insoluble mercuric albuminate, scarcely a trace of mercury is left in the solution.

2. Solution  $\text{HgI}_2 + \text{KI}$ , definite strength, added to partly defibrinated blood, same reaction as in test No. 1.

3. Solution  $\text{HgI}_2 + \text{KI}$ , definite strength, added to serum of the blood, same reaction, resulting in an almost complete precipitation of all the  $\text{HI}_2$ ; and this trace I think results from the impossibility of knowing the saturation point of the combining of the albumen with the mercury to form the mercuric albuminate. Where the albumen is greatly in excess this precipitate is re-dissolved, but this fact makes this  $\text{HgI}_2$  too uncertain to be depended upon. Who can tell, when such a solution is used, whether there is or is not sufficient albumen to dissolve the almost insoluble precipitate first formed? These tests undoubtedly leave the tartaric-acid solution of mercury, as suggested by E. LaPlace, the only reliable antiseptic known. Tests have repeatedly been made with this preparation in all kinds of albuminous fluids without the least precipitation. *H. A. Hare, M. D., Ibid.*

**TREATMENT OF PNEUMONIA BY APPLICATION OF ICE.**—Dr. Fieandt, writing in *Duodecim*, a Finnish medical journal, states that he has treated no less than 106 cases of pneumonia with ice, and with the best results. Though ten of the cases were of double pneumonia, only three out of the whole number succumbed, notwithstanding that the epidemic was by no means a slight one. The method adopted was to apply over the affected lung an india-rubber bag containing ice continuously for from

twelve to twenty-four hours after the crisis. In addition to the local treatment the patients were given such medicines as are usually employed, that is to say, opium, ipecacuanha, digitalis, brandy, etc. The method has, we may remark, received of late some attention in this country.—*London Lancet.*

**THE BICHLORIDE OF MERCURY TREATMENT OF GRANULAR LIDS.**—Probably no more troublesome affection of the conjunctiva falls to the lot of the surgeon than granular conjunctivitis in its various forms. To merely enumerate the local remedies which have from time to time been applied and advocated for the relief of this affection would occupy many lines. Each new remedy is for the time hailed with delight as promising better results than previous drugs have given, only, in most instances, after a trial to be set aside as affording no more relief than standard applications like nitrate of silver and sulphate of copper. So true is this general distrust of different washes, lotions, and applications that the radical measures of shaving off the granulations, crushing them, and destroying them with the actual cautery have been and are largely practiced.

Perhaps not a little of the difficulty in successfully conducting the treatment of trachoma depends upon the extraordinary differences of opinion as to the origin of the granulations. It is reasonable to hope that the solution of this difficulty will be simplified if the theory that granular lids are due to the presence of a specific micro-organism be proven. Certainly, from the bacteriological standpoint, the treatment of this disorder with bichloride of mercury is entirely rational and deserves extended trial. Arnauts (*Annales d'Oculistique*, Jan.-Feb., 1889,) records the experience of three years at the Clinic of Dr. Romée, in which the following method proved very satisfactory. Twice a week the conjunctiva was brushed over with a solution of corrosive sublimate, 1-120 or 1-100, and three times daily a collyrium of the same drug of the strength of 1-500 or 1-400 was instilled into the eye. According to the author the latter produces some irritation, but this may be allayed, especially in sensitive patients, by the use of cocaine. More than a year ago Staderini (*Rec. d'Ophtalmologie*, Feb., 1888,) wrote concerning its value. The method there advocated was to employ a solution for general use of 1-400; if there was much co-existing corneal mischief, 1-500; and if the granulations were dense, 1-300. At the same time

the eyes were thoroughly irrigated every two hours with a tepid solution, 1-7,000.

As far as our experience goes and it is now not an inconsiderable one) a useful strength for ordinary cases is 1-300, 1-120 being reserved for the instances of thick granulation, while at the same time a collyrium should be prescribed of the strength of a grain to the pint to be used four times a day. The stronger solution recommended by Arnauts seems likely to occasion sufficient irritation to somewhat defeat the object of the treatment. Not only is this method applicable to the treatment of granular lids, but it may safely be employed—at least the solution of 1-500—in cases of chronic blepharitis of the conjunctiva, the lids being everted, and the solution carefully applied with a camel's hair brush or mop of absorbent cotton.—*University Medical Magazine*.

**FETAL MALARIA TRANSMITTED BY THE FATHER.**—The very considerable susceptibility of the fetus *in utero* to various diseases, infectious and otherwise, has been naturally most widely associated with conditions of the maternal organism, from the fact of the long continued and intimate connection of the child with the mother as compared with that which it has with the father. The mother's power for infecting the fetus is, in other words, twofold; namely, by a vitiated ovum, and also *post conceptum* by influences operating through the placental circulation; while the father has but one such opportunity, namely, by a vitiated spermatozoon.

In the case of one malady, syphilis, it is held by most authorities that the infection of the fetus may be conveyed solely by the father, the mother remaining uninfected unless by the syphilitic occupant of her uterus.

Tuberculosis, if inherited, shows itself so much later than syphilis as greatly to complicate the problem of its transmission. A few instances in the human subject and in the calf seem to show that the bacilli can traverse the placenta from the maternal organism, and though Chonheim, with others, taught that tuberculosis was transmissible in the semen and in the ovum, it must be confessed that the drift of recent opinion is against its being conveyed in the generative element of either parent, or at least of the male.

It is possible that in the study of fetal malaria we may find an aid to the solution of some of these problems of pathological inheritance; for we have here a disease at once infectious and chronic, and like syphi-

lis rather than tuberculosis early in its manifestations after birth. The existence of fetal malaria has been sufficiently demonstrated by the observation of icterus neonatus and neonatal chills accompanied by an enlarged spleen, occurring in the child of a similarly affected mother. It soon was in fact that at the time of conception she was obviously infected throughout the pregnancy, so that the transmission of malaria *per ova* could not be demonstrated, besides which transmission *per placentam* could not be eliminated. So far as we recall, no instances have hitherto been recorded where, the child showing malaria, the father alone of the parents has had the disease.

We find, however, in the Edinburgh Medical Journal for June, two cases of great interest in this connection recorded by Dr. R. W. Felkin, Lecturer on Diseases of the Tropics and Climatology in the Edinburgh School of Medicine. In both the father had well marked malaria, and the mother was free from it, yet the child showed symptoms of the infection.

In the first case, the husband had contracted, on the west coast of Africa, both remittent and intermittent fever, on account of which he threw up his situation there, and went to the island of Madagascar, where he met a Lancashire woman and married her. They remained at Madagascar eight months and then went to Durban, Cape of Good Hope, the wife being eight months pregnant, and never having had any symptoms whatever of malaria. A week after her arrival Dr. Felkin saw her, complaining of a curious sensation in the abdomen, and he distinctly felt the fetus slinking. The lady said the same thing had happened on several previous occasions, though never so markedly before. The phenomenon occurred at the same hour for four consecutive nights, when labor came on. Forceps were called for, and delivery was assisted by the distended abdomen of the child caused by enlarged spleen. After birth the child had seven attacks of ague, characterized by the cold, hot, and sweating stages. The paroxysms lasted seven hours in all, and the rectal temperature was 102°. The father stated that just before and for the month following his marriage, he had had several very severe attacks of ague.

A possible objection to assigning the entire responsibility for this case to the father lies in the fact that, after removal to Durban, they were in a place where malaria might be contracted, though of course the assumption of the woman from all symptoms, and

her short stay, would make her a very improbable medium for transmitting the affection to the child; besides that, she stated that similar though less extreme shakings of the fetus had been observed by her before.

In the second case the child's parents had been married twelve years. The mother had never been away from Edinburgh. Three children had been born, all at full time, and quite healthy, during the first seven years after the parents' marriage. The father then went as fireman on a steamer trading with West African ports. The men were forbidden to land at the ports, but the second engineer and this fireman managed to escape several times, and had severe remittent fever. The engineer died, and his death so frightened the fireman that he did not go on shore again, although he remained another year in the service suffering from ordinary ague. He had never suffered from syphilis. Ten months after his return home a child was born at full time, but it soon "pined away and died." Rather more than a year later another child was born, which was always ailing, and had a rather enlarged spleen, but was greatly improved by appropriate treatment.

In the last and sixth pregnancy Dr. Felkin observed an attack of pain and fluttering "like a bad quickening," which lasted an hour, and recurred in twenty-four hours, and again forty-eight hours later. The woman described it as like attacks she had had with her two previous children. Labor came on after one of these attacks, and the child was born at seven and one half months. After birth it had two attacks of ague, at intervals of twenty-four and forty-eight hours respectively, and died in the cold stage of the second. In the first attack after birth the cold stage was very well marked, the child distinctly shivering, and continuing to do so for rather more than half an hour. The hot stage lasted about two hours, and was followed by fairly profuse perspiration, the cotton-wool in which the child was wrapped becoming quite wet. During the attack the temperature was taken several times, and the highest point reached was 102.6°. The *post-mortem* appearances were fairly confirmatory of the clinical diagnosis of malaria.

If these cases be substantiated by other similar ones, they will go to place malaria beside syphilis as one of the diseases which can be transmitted directly from the father to the child without the necessary infection of the mother; and if the plasmodium ma-

larise can gain access to the spermatozoon, may not, after all, the bacillus?—*Boston Medical and Surgical Journal*.

**A NEW OPERATION FOR LACERATED PERINEUM.**—A new operation has been proposed by Mr. Alexander Duke for the repair of lacerated perineum, which seems to possess some advantages, in certain cases at least, over those at present in vogue. The procedure, which is described in the *Dublin Medical Press* of May 9, 1889, is apparently quite simple, and if it prove to be as efficacious as Mr. Duke believes it will, it ought to take rank among the recognized operations for the relief of this condition.

The method is in brief as follows: The patient is placed either in the lithotomy or Sims' position, the left index finger being introduced almost its entire length into the rectum; a long, straight, double-edged bistoury is made to pierce the tissues in front of the anus at right angles to the vulva; and, guided by the finger in the rectum, is made to penetrate the septum for two and a half inches upward, the incision being enlarged laterally to two inches at least, as the knife is withdrawn. On the two points of incision being pressed together from side to side a lozenge-shaped opening appears, and when all the sutures required have been introduced and are properly adjusted and approximated, the two cut surfaces are brought into direct apposition. The sutures are introduced by a strong sickle-shaped needle with eye in the point, mounted on a handle, strong silver wire being the suture preferred. The needle is introduced at the center of the skin incision below, and, guided by the finger in the rectum, is made to travel over the cut surface to its full extent above, describing the arc of a circle, and, on the point of needle appearing directly opposite, it is threaded with the suture and drawn through. When all the necessary sutures have been introduced and approximated, a finger of each hand passed into the rectum and vagina will at once recognize the gain in thickness of the septum, the external tissue being pushed fully an inch forward from the anus, and forming a thick and solid perineal body. The incision being a deep one, on union taking place between the raw surfaces, a considerable depth of support must be afforded where a pessary is required, or where there is much tendency to prolapse of the uterus or vaginal walls.

Mr. Duke's experience of the operation, although up to the present limited, has satisfied him, he says, with the results, and, there being no loss of tissue whatever, should the operation fail, it can not add any difficulty to a subsequent one. The following are the advantages which he claims for the operation:

1. The simplest of performance as yet proposed. No danger of hemorrhage, the surfaces being brought together at once, and the wound is dry and clean.

2. No danger of sepsis, as the incision is not open for the admission of any discharge from either vagina or rectum during the healing process.

3. No loss of tissue, and consequently no harm done should the operation fail.—*Medical Record*.

**BLINDNESS IN ENGLAND.**—The number of the blind in the United Kingdom, according to the last census, was 32,296, says the *London Times*, being at the rate of 879 blind persons per million of the general population as compared with 950 in 1871, 964 in 1861, and 1,021 in 1851. The decrease in blindness would thus appear to be gradual but steady, even allowing for the fact that many who have very defective sight, and are practically blind, object to return themselves as such. The number of those of school age in England and Wales is 1,710, or one thirteenth, a surprisingly small proportion, which points to the fact, well known to specialists, that blindness as a rule supervenes in later life, the average age of the blind being forty-nine. Their general condition has been much improved of late years, owing to the prevalence of more enlightened notions and the increase of special institutions. But the commissioners remark that, in spite of the large charitable funds and philanthropic efforts devoted to their welfare, they feel convinced that much may be done to better the condition of the blind and render them more independent of charitable aid than at present.

Accidents from flying pieces of stone or chips of metal are accountable for 58 per cent of injuries to the eye; and in the case of 4 to 4½ per cent of such accidents, the sympathetic inflammation of the remaining eye, which so often sets in, leads to total blindness. Shuttle accidents, formerly very frequent, were diminished by the introduction of shuttle-guards, and the number of cases at the Royal Eye Hospital, Manchester decreased from twenty-one in 1884 to nine in 1885. Strong protective glasses of talc or mica, or fine wire goggles, are a valuable safeguard against such calamities, and early surgical treatment is of high importance. Granular ophthalmia in badly ventilated and badly lighted dwellings is another cause, but with proper sanitary precautions this is preventable; and during the recent occupation of Egypt no loss of sight

from ophthalmia occurred among our troops, owing to the excellent care exercised by the medical staff.

One of the most fruitful causes of blindness is the inflammation of the eyes of newly-born infants, and the Ophthalmological Society estimated that 30 per cent of the inmates of the institutions, and 7,000 persons in the United Kingdom, had lost their sight from that cause. Various specifics are mentioned by the commissioners, but they all seem to depend chiefly for their success on prompt application. — *Boston Medical and Surgical Journal*.

**PATHOLOGICAL INFERIORITY OF THE LEFT SIDE OF THE HUMAN BODY.**—When a unilateral lesion attacks any of the decussate organs of the human body, the left organ is more frequently affected than the right. Thus, obliterating arteritis attacks the left Sylvian artery; tuberculous infiltration occurs in the left apex; pneumonia in the left lung; calculous nephritis, or cyst of the kidney, attacks the left kidney; ovaritis and ovarian hyperæmia are observed in the left ovary; orchitis affects the left testicle, etc. M. Henry Duchenne tries to explain this fact by the greater activity of the right side of the body and the relative passive condition of the left side, which contains the heart. The mechanical activity of the right side determines nutritive activity. The mechanical passivity of the left side produces a kind of physiological mealiness, a pathological predisposition. Dr. Duchenne considers that the law of atavism may also explain the physiological inferiority of the left side of the body, for in ancient times, when hand-to-hand fights were always occurring, the activity of the right side of the body was constantly called into play. — *Medical Recorder*.

**PYO-STERCORAL FISTULA CURED BY ENTERORRHAPHY.**—(By Prof. TREUB, Paris.) A pyo-stercoral fistula is a more or less irregular channel running between the intestine and the external surface of the body, and giving passage to pus and fecal matter or to pus alone. It is to be distinguished from a fecal fistula or an artificial anus by the presence of a suppurating cavity between the intestine and the external opening.

Pyo-stercoral fistulæ are rare. The chief causes, in order of frequency, are ill-defined abscess, perityphilitis, abscesses with escape of intestinal worms, perianterine inflammation and perinephritis abscesses. The intestinal perforation generally occurs before the skin is perforated. From a clinical point of view these fistulæ are distinguished by their slow

formation and long duration, and also by the fact that from time to time they appear to be perfectly healed, only, however, to break down again in no long time. When death occurs it is generally from retention, hectic, etc. Peritonitis is rare as a cause of death.

As regards treatment, the only method which offers a certain chance of cure is suture of the intestinal opening, but unfortunately this can not be practiced in those cases where there is more than one fistulous passage into the intestine, and where the intestine itself is so bound down by adhesions that it can not be freed. These secondary fistulous tracts are generally the result of treatment; naturally there is, as a rule, only one tract. In those cases where enterorrhaphy can not be performed M. Trélat recommends Verneuil's treatment, viz., to lay the abscess cavity open and cauterize freely in the hope that the ensuing cicatricial changes may so mend matters that enterorrhaphy may eventually be performed. Failure of the suture is inevitable unless the intestine can be entirely freed from adhesions.

Umbilical pyo-stercoral fistulæ and those resulting from periuterine inflammations are the most difficult to treat satisfactorily; the former on account of the long and often complicated track of the fistula, the latter from the presence of extensive adhesions.—*Dr. J. Anderson Smith, Annals of Surgery.*

INSANITY FOLLOWING MUMPS.—Insanity is well known to be associated with several of the infectious fevers as a complication or sequela, but I am not aware that cases following mumps have ever been recorded. Mumps is not mentioned in the ordinary text books on insanity under the heading of "Post-febrile Insanity," and therefore the following cases have appeared to me to be worth recording:

I. G. R. R. T., a clerk, aged nineteen, was admitted into Bethlehem Hospital on June 19, 1888. He had enjoyed very good health previously to this illness and had never suffered from insanity before, and there was no neurotic inheritance. A fortnight before admission he had suffered from mumps, there being other cases in the family and in the same village. His attack was associated with diarrhea so severe as to be called "English cholera" by the doctor attending him. The patient was said to have been extremely exhausted and almost pulseless afterward, and was described by his friends to have been "nearly gone." On

recovering from this about five days before admission he became excited, sleepless, and rambling, and passed into a condition of acute mania, in which state he was admitted to hospital. There was no special feature about his insanity while in the hospital; he rather rapidly improved, and was discharged recovered October last.

II. This case occurred in a young medical man who had an attack of mumps that was complicated with severe orchitis, for which he was admitted to a general hospital, and as a result of which he became depressed and suspicious, thought he was guilty of imaginary crimes for which he dreaded punishment, and was suicidally inclined. He had a short attack of melancholia, which passed off with improvement in his physical health, and eventually he recovered perfectly without the necessity of being sent to an asylum.

It is worthy of note that in both cases there was a severe complication associated with the mumps, so that there was considerable physical exhaustion, this seeming to have more to do with the attack of insanity than any severe febrile process or metastasis.—*Dr. R. P. Smith, London Lancet.*

CASE OF SUPRA-PUBIC OPERATION OF OPENING THE BLADDER FOR STONE.—W. B., aged sixty-eight, consulted me about four years ago, when he suffered from chronic bronchitis, pain on micturition, and was passing gravel. About twelve months ago he passed some bloody urine, but this symptom has only appeared twice since. I sounded him for the first time in June, and discovered the presence of a stone; but from the symptoms then and in subsequent soundings I concluded that the stone was encysted, and from its position not easy to reach by the ordinary operation of lithotomy, so determined upon the supra-pubic operation.

On Wednesday, July 3d, I performed the operation, having first distended the rectum with an india rubber ball of ten ounces capacity. I injected ten to twelve ounces of boracic solution into the bladder, carefully dissecting and scratching my way through the tissues. The knife was only used three times. I had no difficulty in reaching the bladder and in extracting the stone, which was, as I had supposed, encysted, and not to be easily discovered; in fact, I at first thought there was no stone, as only a very small surface could be felt, and requiring some little manipulation to free it from its cyst walls. A drainage-tube was passed from the external wound through the urethra, and left *in situ* about five days. The patient has made an uninterrupted recovery, and is

now (July 26th) passing all his urine by the urethra, and the wound is nearly healed. The operation was attended by very little hemorrhage, all veins being held aside, and was much easier to perform than the perineal operation. The stone is about an inch long, half an inch broad, and weighs one dram, five grains.

I place this case upon record, as the high operation is only recommended for large calculi; but in all cases of encysted calculi I strongly advise it, and believe it the best resource.—*C. A. Corke, Phil.*

**CONDURANGO WINE.**—Although condurango has not entirely justified the claims made for it in the treatment of cancer, the experiments made with it have demonstrated its utility as a stomachic, and in the form of condurango wine it has grown to be very much in demand, especially in Europe. One fluid ounce of the wine represents 60 grains of condurango bark. Dose one half to one fluid ounce. Parke, Davis & Co. supply the wine and also a fluid and solid extract of this drug, and will also mail, on request, a working bulletin on condurango to physicians who wish more detailed information concerning it.

**ARSENITE OF COPPER TABLETS,  $\frac{1}{100}$  GRAIN.** An article by Dr. J. Aulde on the application of arsenite of copper in bowel affections, and especially in the diarrhea of typhoid fever, was published in the July, 1889, *Therapeutic Gazette*. The results obtained by this investigation were so favorable to this remedy that Parke, Davis & Co. added to their list of tablets a  $\frac{1}{100}$  grain arsenite of copper tablet, which makes a convenient method of preparing the solution commended by Dr. Aulde. One tablet should be dissolved in three, four to six ounces of water, of which the dose is a teaspoonful. Reprints of Dr. Aulde's article furnished physicians by Parke, Davis & Co. on request.

**PULSATILLA IN THE TREATMENT OF EPIDIDYMITIS.**—Acting upon a suggestion made by Mr. Berkeley Hill, to whose kindness I am indebted for permission to publish the following results, for some time past patients at the Male Lock Hospital with gonorrheal epididymitis have been treated by the internal administration of pulsatilla. The drug was exhibited in the form of the tincture, the doses given varying from five to thirty minims every four hours. One patient only complained of nausea after taking the drug. In the case of patients taking the larger dose the pulse-rate was perceptibly lowered, although in one case in which ob-

servations were made no diminution of temperature took place. Without going into the details of the case, I find from comparisons with others treated by the usual methods that in no instance was the duration of pain and tenderness less than the average, and, in fact, in several cases treated by pulsatilla alone, without local applications, the pain lasted rather longer than usual. The severity of the inflammatory process, as evidenced by the amount of pus-like exudation thrown out, does not appear to be influenced at all by this drug. In fact cases treated by it pursued the same course as when treated by simple rest in bed, abstinence to the emunctories, etc.; and, according to my experience of the drug, it is not even a useful adjunct to the treatment of epididymitis. *Robert J. Carter, London Lancet.*

**CASE OF ACUTE ORCHITIS WITH ALARMING CONSTITUTIONAL SYMPTOMS; RAPID RECOVERY.**—**J. B.**, a healthy country lad, aged fifteen, just recovered from an attack of whooping-cough, complained on June 26th of headache, loss of appetite, feverishness, general feeling of *malaise*, and pain and tenderness in the right testicle, which he observed to be somewhat swollen. The constitutional symptoms increased in severity, and became so alarming that I was sent for in haste early the following morning. I found him delirious, taking no notice of any thing except when roughly shaken, and then quickly relapsing into unconsciousness. His face had a dull, stupid look; tongue far red; pulse 120, full and bounding; temperature 103.2°; chest sounds normal; enlargement of testicle uniform, and of but moderate extent. There was no history of a cause. I gave him a mixture containing sulphate of magnesium, tartrate of antimony, and tincture of hyoscyamus, a dose to be taken every four hours; the testicle to be supported on a pillow, fomented every couple of hours with hot water, and afterward smeared with a lotion containing equal parts of glycerine and extract of belladonna. The testicular inflammation being moderate, I did not deem local blood-letting necessary. A marked improvement had taken place in the evening. He was quite conscious; his temperature had fallen to 101.6°, and the pulse to 104. As his bowels had not moved, I ordered a dose of castor oil. On the morning of the 28th, having slept well during the night, he seemed to be quite convalescent. His face had a bright, healthy look, his appetite had returned, all feverishness had disappeared, and his temperature and pulse were normal. From this date the enlargement of the testicle rapidly diminished, until on July 5th no trace of it remained.—*Dr. G. J. Poore, Ind.*

# The American Practitioner and News

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D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } - - - Editors.

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## THE MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

The fifteenth annual meeting, held at Evansville, Ind., September 10th, 11th, and 12th, was the most successful that the Association ever had. It was notable above all others for the scientific work accomplished, for the large attendance, and the good cheer provided by the hosts, the profession of Evansville.

If we had any criticism to offer, it would be the great length of the programme which necessitated the reading of a large number of good papers by title only. The convention was right in its decision not to divide into two sections, a surgical and medical. A bright idea was that of the president in grouping together papers bearing on the same subject, and having the discussion to take place only after all had been read. This rendered the group which dealt with tuberculosis a very interesting feature of the session.

The hours devoted to work were greater than at any similar meeting of the convention; nevertheless, the social features were of such proportion and character as to be long remembered by those who enjoyed Evansville's open-hearted hospitality. The

banquet at Garvin's Grove, and the concert and ball at Evans' Hall were especially noteworthy.

The Nominating Committee selected Dr. J. M. Mathews, of this city, to be its next president, and the convention was a unit in indorsing the nomination. The honor could not have fallen upon a worthier gentleman. Louisville was selected as the city to entertain the Association next September, Dr. I. N. Bloom being chosen chairman of the Committee of Arrangements. It is to be hoped that the profession of the city, as well as of the whole State, will unite, as did that of Evansville, in making the meeting a memorable one.

Elsewhere in this issue will be found a full report of the meeting and four of the papers read. Through the kindness of their authors we have received a dozen or more of the best papers. We desire to thank these gentlemen for their courtesy. They will all appear in due order.

THE government of Chili has created a "Superior Council of Public Hygiene," consisting of seven members, whose duty it shall be to advise the government in every thing that relates to the public health throughout the republic. The council has a laboratory for chemical analysis under its control.

A PHYSICIAN, sixty years of age, killed himself not long ago, in Paris, because he was unable to make enough from his practice to pay his rent. According to the Medical Record a very similar case occurred in New York not long ago, when an aged physician shot himself after vainly seeking death by poison.

DR. SIGMUND LUSTGARTEN, formerly of Vienna, has removed to America, and intends to reside in New York. Dr. Lustgarten was for some time a Privat-docent in Vienna, and in that way is known to many Americans. He is widely known as the discoverer of the bacillus of syphilis, which is called by his name.

## Notes and Queries.

AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS.—In the address of Dr. Wm. H. Taylor, President of the American Association of Obstetricians and Gynecologists, at the meeting in Cincinnati, September 17th, 18th, and 19th, he expressed his satisfaction with the success of the first meeting at Washington, and hoped this second annual meeting would be as productive of scientific progress. He reviewed the advances made during the past year in this department of medicine, and referred to the increased accuracy in diagnosis which made the condemnation of laparotomy less frequent. The statistics of Munchmeyer and recent utterances of Sir Spencer Wells emphasize the propriety of uterine extirpation. The low death-rate of myomata and great mortality from operation for their removal suggest rare resort to operative procedure. The management of the third stage of labor has been debated in Germany for several years with apparently small advantage to either combatant or science. One author states that "one woman dies in Prussia every day from *post-partum* hemorrhage." So eminent an authority as D. Berry Hart has said that he considers the *Credé* the most dangerous plan possible for the removal of the placenta. With our idols being shattered about us, it behooves us to carefully survey the ground upon which our confidence is built.

The results of cesarean section recently establish it as an operation of resort, if the obstetrician would escape censure, and our judgment must determine to which cases the Porro modification is best adapted, and to which the Saenger is most appropriate. Ectopic pregnancy, pelvic suppuration, and craniotomy have such consideration on the programme that time spent on their discussion here would be superfluous.

No prophetic power is required, in the light of the progress in our branch of medicine in the past decade, to assure us that in the land still to be possessed there are wide possibilities, and we dare place no limit on

the possible acquisition of the near future. The Utopias of to-day may be the familiar dwelling-places of to-morrow, and I can utter no better benediction than the hope that this Association may bear its full share in achieving these grand and glorious ends.

The following papers were read: Congenital Sinuses of the Urachus, Abdominal Incision, Recovery, with remarks, by Dr. A. Vander Veer, Albany, N. Y.; A case of Extra-Uterine Pregnancy, Operation, and Recovery, by Dr. L. S. McMurtry, Danville, Ky.; Intra-Uterine Cord, Amputation of the Fetal Extremities, Dr. Joseph Price, Philadelphia; Flap Splitting in Perineorrhaphy, with special reference to Tait's operation, Dr. X. O. Werder, Pittsburgh, Pa.; Vaginal Hysterectomy, Dr. E. E. Montgomery, Philadelphia; Supra-Vaginal Hysterectomy, Extra-peritoneal Dry Treatment of the Pelvis, Dr. Joseph Price, Philadelphia; Successful Removal of a Fibrous Tumor of the Right Ovary During Pregnancy, Dr. J. H. Carstens, Detroit, Mich.; A Remarkable case of Nymphomania, Dr. W. S. Stewart, Philadelphia; A few Considerations on Peritoneal Effusions after Intra-Peritoneal Operations, Dr. W. H. Meyers, Ft. Wayne, Ind.; The President's Annual Address, Dr. Wm. H. Taylor, Cincinnati; Reasons for Drainage in Ovariectomy, Dr. Hampton E. Hill, Saco, Maine.

On the afternoon of the third and last day the session was given up to the discussion of the subject: Is craniotomy justifiable on the living children, and its alternatives?

Listerism received some hard knocks, as did also electricity in gynecology. One gentleman, who was especially severe and a good deal more positive than our science will allow, said electricity was used only by the ignorant, and those who had never been in the abdomen. He cited as a specimen a doctor in his city who was a great advocate of electricity, and he scarcely knew whether the pubes or the sacrum was bored. This same speaker, after having vented his venom on listerism and electricity, turned to compliment a Fellow who had agreed with

him in his paper, and said he described a case as perfectly as *Mozart* could have painted it. If his ignorance of Listerism and electricity was as profound as his familiarity with music and painting, it is not to be wondered that he avoids them.

Another antagonist of electricity made a boast that he had not a battery in his office. Drainage was discussed freely, and as a general thing warmly indorsed. One gentleman, Dr. Hill, reported twenty-six ovariectomies, in which he used the drainage-tube twenty-four times, and had twenty-five recoveries. He made twelve ovariectomies without losing a case before he ever saw the operation done. His work was highly praised by the members. Flap-splitting in perineorrhaphy was severely condemned. Abdominal surgery was lauded to the skies and should be limited to the hands of the specialist.

Socially, the Association was very kindly entertained. The city of Cincinnati was thrown open to delegates. Dr. A. and Mrs. Taylor gave a reception, to which the Association was invited to meet the local profession. This was a very enjoyable occasion, and the Cincinnati doctors made themselves as agreeable as possible. The local members took the Association to see Montezuma, or the Conquest of Mexico, which was also very much appreciated.

The election of officers resulted as follows: President, Dr. E. E. Montgomery, Philadelphia; First Vice-President, Dr. W. H. Meyers, Fort Wayne, Ind., Second Vice-President, Dr. R. L. Banta, Buffalo; Secretary, Dr. W. W. Potter, Buffalo; Treasurer, Dr. X. O. Werder, Pittsburgh; Executive Committee, Dr. A. Vander Veer, Albany, N. Y., Dr. C. Cushing, San Francisco, Dr. W. H. Wathen, Louisville, Ky., Dr. C. A. L. Reed, Cincinnati, Dr. H. B. Hill, Saco, Me.

The Association on meeting in Cincinnati numbered thirty-eight members, of whom twenty were present. Fifteen new members were added at the Cincinnati meeting. Place of next meeting, Philadelphia, third Tuesday, Wednesday, and Thursday in September, 1890.

E. S. M'KEE, M. D.

**SHOT-GUN QUARANTINE.**—It looks very much as if the teachings of the U. S. Marine Hospital Service in regard to the prevention of the spread of epidemics had penetrated further in the lay mind than is generally supposed. The news comes from the far West that two deaths have followed a somewhat literal interpretation of some of the methods used against yellow fever in Florida a year ago. It is reported that on July 26th a certain Deputy Sheriff Moore, who, with some kindred philanthropists, was engaged in the laudable work of driving out from the town of Wallace, New Mexico—no doubt with guns—one Joseph Chacha, a smallpox attendant, was turned upon and killed by the thoughtless Chacha, and that thereupon the smallpox attendant was himself riddled with bullets by the angry crowd. Now, it is possible that Chacha had committed some offense besides that of caring for his fellow-men stricken with a loathsome and dangerous disease; but this does not appear in the account which we have seen. Physicians have an interest in this way of dealing with contagion; for there is no telling—if it goes on—when the community may take to shooting doctors who attend yellow-fever or smallpox patients, and then half the pleasure of practicing medicine will be gone.—*Medical and Surgical Reporter*.

**A JUDGE'S OPINION ON THE USE OF THE TITLE HOMEOPATHIST.**—Judge G. C. Barrett, of the Supreme Court of this city, sends to the New York Medical Times an opinion which will be read with much interest. He was asked to give a reply to the question, "Has a physician designating himself a 'homeopathist,' and called as such to a patient, any legal or moral right to adopt other than homeopathic means in the treatment of the case?" To this Judge Barrett answers:

"I have your note of the 11th instant, asking my opinion upon a question of professional ethics. In my judgment there can be but one answer to your question, and that is in the negative. If I call in a medical man who designates himself a 'homeopathic physician,' it is because I do not wish to be treated allo-

pathically, or eclectically, or otherwise than homeopathically. There is an implied understanding between myself and the homeopathist that I shall receive the treatment which, by tradition and a general consensus of opinion, means small doses of a single drug administered upon the principle of *similia similibus curantur*. If there is to be any variation from that method, I have a right to be informed of it and to be given an opportunity to decide. Common honesty demands that before a confiding patient is to be drugged with quinine, iron, morphine, or other medicaments, either singly or in combination, he should be told that the 'homeopathist' has failed, and that relief can only be afforded by a change of system. An honest 'homeopath,' who has not succeeded, after doing his best with the appropriate homeopathic remedies administered on homeopathic principles, should undoubtedly try any thing else which he believes may save or relieve his patient. But when he reaches that point the duty of taking the patient into his confidence becomes imperative. The patient may refuse to submit to the other system or he may agree, but prefer a physician whose life has been specially devoted to practice under that other system. He may say to the 'homeopathist': You have failed, but I prefer to try another gentleman of your own school before resorting to a system that I have long since turned my back upon. Or he may say, Well, if homeopathy cannot save me, I prefer to go to headquarters for allopathic treatment. All this, gentlemen, is the logical sequence of the particular designation 'homeopathist.'"—*Brooklyn Medical Journal*.

**TYPHOID FEVER IN MONTREAL.**—About this time of year cases of typhoid fever usually multiply, and reports of this are coming from all parts of the civilized world. Under date of September 4th it was reported that typhoid fever is epidemic in the most thickly populated district of Montreal. Numbers of people were dying daily, while hundreds were stricken with the disease.

One of the most remarkable features of the outbreak and spread of the disease is the assertion that one of the physicians of

the district is accused of being responsible for the outbreak. It is alleged that being called in to attend a typhoid patient, the daughter of a woman who supplies the greater part of the city's demand for milk, he accepted a bribe from the milk woman to conceal the nature of her daughter's malady so that she would not lose custom, and it was through this milk monopoly that the disease so rapidly spread.

In reply to this charge the physician says that he is satisfied the daughter was not suffering from typhoid fever. In any case, he says, he had no power to stop the sale of the milk.—*Medical and Surgical Reporter*.

**ABSOLUTE SIGNS OF DEATH.**—Dr. B. W. Richardson suggests the following signs as actual proofs that must be made in order to demonstrate satisfactorily that life is extinct: (1) Respiratory failure; (2) cardiac failure; (3) reduction of temperature below the natural standard; (4) the presence of *rigor mortis* and muscular collapse; (5) coagulation of blood in the veins; (6) the presence of putrefactive decomposition; (7) absence of a red color in semi-transparent parts under the influence of a powerful light, such as that from a magnesium lamp; (8) absence of muscular contraction under the stimulus of an electric current; (9) the absence of a red blotch under the skin after the subcutaneous injection of ammonia; (10) absence of signs of rust on a bright steel needle after plunging it deep into the tissues.—*Brooklyn Medical Journal*.

**THE FUNCTIONS OF THE CEREBELLUM.**—Is the cerebellum an organ for the storage of cerebral events which have become automatic? Do we first of all receive with the cerebral cortex and then practice with the same brain bark, and afterward relegate to the cerebellum, as to a limbo, those things of which we are so tired of being conscious? Are all performances of the cerebral cortex conscious acts, and those of the cortex of the cerebellum unconscious? And so might questions, more or less unanswerable, be postulated without end. The functions of the little brain are scarcely known at all; even the dependence of the

equilibrium on its existence may be called in question on the data supplied by pathology. It is perfectly certain that no obvious signs of nervous disease need exist when the lateral lobes are the seat of even extensive mischief. Some regard the cerebellum as the terminal organ of all visceral sensation, and on this assumption it has been thought that the curious perturbations in visceral epilepsy are to be ascribed to perversions of the vitality of the gray matter of the little brain. Any thing is possible for the cerebellum. The most gifted imagination might guess strange things, yet pathology could perhaps find exact counterparts.—*London Lancet*.

A LITTLE GIRL of Avondale, Pa., died September 9th of hydrophobia, after suffering indescribably for several hours. It was also reported that another child in the same family was in convulsions from the same disease. These children were bitten by a dog in the family in July last.

FLIES AS CARRIERS OF CONTAGION.—Since the recognition that in many diseases the infective principle is particulate, the possible means of conveyance of the virus from one to another individual have widened. Attention has lately been recalled to the part which may conceivably be played in this direction by the agency of the house-fly. Our contemporary, the *Liverpool Mercury* (July 25th), reminds us that the granular ophthalmia of the shores of the Nile—a true plague of Egypt—has been shown to be propagated through this medium; and has further alluded to the discovery by Dr. Alessi that the bacillus tuberculosis may exist in the intestines of flies which have been feeding on phthisical sputa. Indeed, it would appear that there is hardly any direction, either in our mode of living, eating, or environment, whereby we can avert the possibility of the transference to ourselves of this ubiquitous bacillus, and life would become intolerable were it not for the well-grounded belief that phthisis is not dependent for its development upon this microbe solely, but upon the concurrence of

many conditions of almost, if not quite, as much importance as its implantation in the body. Apropos of flies, however, it has been stated that the lamented Father Damien attributed his leprosy to the inoculation, through their agency, of an abrasion in the scalp.—*London Lancet*.

M. PASTEUR, it is announced, has been made a Doctor of Laws by the University of Edinburgh, in view of the importance of his researches on the subject of hydrophobia.

CHEAP MEDICAL SERVICES.—A medical association has been formed in this city which advertises to furnish medical attendance to its subscribers for forty cents a month, and that all prescriptions for its subscribers will be filled by the leading pharmacists of the city for twenty cents for each prescription. In all probability the services and medicines are not even worth that.—*Medical Record*.

THE will of Dr. Gross provides that there shall be an award of \$1,000 every five years for the best essay in surgical pathology or practice. The Philadelphia Academy of Surgery will have charge of the conditions and terms of the competition. The successful competitor must be an American citizen. All essays, in the first contest, must be forwarded to the Academy before June 1, 1893.

THE QUARTERLY COMPENDIUM OF MEDICAL SCIENCE is no more. The editor informs us that it is suspended for the present, that the work of the office may be concentrated on the *Medical and Surgical Reporter*.

#### SPECIAL NOTICE.

L. C. CARR, M.D., Professor of Obstetrics, Cincinnati College of Medicine and Surgery, Cincinnati, Ohio, says: "I have given Papine (Battle) a fair trial and am well pleased with its action, especially so in the case of an infant suffering with an attack of convulsions. Its action was speedy and safe."

GNORRHEA. — Robert S. Anderson, M. D., Spennymoor, England, says: I have found your S. H. Kennedy's Extract of *Pinus Canadensis* of great service as an injection in cases of gonorrhea.

# THE AMERICAN PRACTITIONER AND NEWS

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*Certainly, it is excellent discipline for an action to feel that he must say all he has to say in the first possible moment, and that he must be sure to skip nothing, and at the present possible time in his reason and certainly misinterpreted time. I think, if a downright fact may be told in a plain way, and not with downright facts at present more than one thing is possible.*

## Original Articles.

### A SIMPLE METHOD OF TREATING FISTULA IN ANO.<sup>2</sup>

BY JOSEPH M. MATHEWS, M. D.

*Professor of the Principles and Practice of Surgery and Diseases of the Rectum, in the Kentucky School of Medicine, etc.*

Perhaps a better caption for this article would be "The Treatment of Fistula in Ano," inasmuch as it will be necessary for me to mention the several accepted methods of treatment, in order to contrast or show the advantages of the simple method which I shall speak of in the few selected cases in which it can be used. Fistulae in ano are as varied and different in their pathological conditions as any one surgical affection can be. For instance, a sinus may exist just underneath the skin, extending but a very little distance, and causing but little if any disturbance. Again, sinuses may be so extensive as to completely undermine the sphincter muscles, cause great destruction of tissue, progress rapidly, and so affect the general constitution by the waste and nervous disturbance as to render the patient a complete invalid. Both of these conditions receive the same appellation, viz., fistula in ano. To say that the same method of treatment is applicable to both would be questionable, and yet it is no uncommon thing for us to read in reputable medical journals prescriptions (?), etc., for the cure of fistula, or as might be properly objected to this caption, "A Simple Treatment of Fistula in

Ano." Hence I have been obliged to saying that the method depends upon the case. It is not the intention of the paper to deal with the etiology of the disease, but simply to discuss the methods that have been proposed and are practiced for its radical cure.

From time immemorial the knife has been used as the means *par excellence* for the treatment of fistula, and I might add that from time immemorial has the battle fought against its use. Recognizing that prejudice the charlatan has been ever ready to play to it and has in his pretentious and crafty way increased this prejudice. I believe that every surgeon here will agree to the statement that it would be impossible to cure the larger proportion of fistula without the cutting operation. I can safely say that whenever other methods, such as quiesces, ligatures, etc., are brought in competition with the knife as an agent of cure of surgical affections, the preference must be given the knife. It has always been a mystery to the profession why sensible patients would consent to have tumors, etc., burned out by degrees in lieu of a rapid extirpation with the knife. It is the story of the dog's tail being cut off by piecemeal to avoid giving it pain. It might be said that one of the profession too often succumb to the whims and caprices of patients, often allowing them to dictate the means of cure.

That the cutting operation is the one to be preferred in the majority of cases of fistula is easily understood by those familiar with the disease. Let me illustrate: If an abscess in the ischioanal fossa have left a sinus which runs directly into the rectum, and from this a branch extends upward or up the perineum, nothing save a free division of the two would effect a cure. Add

<sup>2</sup>Read before the Mississippi Valley Medical Association at Evansville, Ind., September 10, 1889.

to this that many fistulæ have branch sinuses, some running laterally, others dorsally, or to the front, and others again burrowing up the bowel; none such could be cured save by a cutting operation. How often it is that the surgeon is disappointed in the wounds refusing to heal after an operation for fistula, and an investigation proves that it is due to the existence of a small sinus or pocket that had been overlooked. I am sure, after a long experience, that in the majority of cases operated on, if a single sinus is left, that a good result will not be obtained. In other words, the inflammation excited will not be sufficient to eradicate the branch fistulæ. The flaps or thinned edges alone, if left, would prevent good union.

CASE: Mr. L. F. S. had submitted himself for treatment to an advertiser who claimed not to use the knife, caustic, or ligature, etc., in the cure of fistula. He had been under constant treatment for eleven months when he discharged his surgeon (?) and consulted me. Upon examination I found five long and deep cuts into the buttocks, evidently made by ligatures, from which was oozing a large amount of pus, showing no disposition to heal. The edges of the wounds fell into the cut surfaces and were a great source of irritation. Inserting my finger into the rectum, a large opening was detected about an inch above sphincter muscle, which communicated with a large sinus running high up in the perineum. The patient was put under the influence of chloroform, and this sinus—which was the original one—was freely divided, several additional branches traced and treated in the same manner. All the edges were trimmed thoroughly and the wounds dressed antiseptically. He made an uninterrupted recovery, and was discharged in two months. This case clearly demonstrates two propositions: (1) That if additional sinuses are left, a cure will not be effected. (2) That any thing less than a free cutting operation would have failed to cure.

Very great prominence is given by some authors to the elastic ligature as a means of cure for fistula. I must confess that the more I use it the less am I pleased with it.

The cases in which it can be recommended are very few, and must be selected with care. No surgeon wishes to do over his work the second time; yet this is sure to be the case very often if the elastic ligature is used indiscriminately. If, as I have asserted, and can easily be demonstrated, the laying open of a main sinus will not eradicate additional or branch sinuses, how can the ligature effect a cure if there be others communicating with the main fistula? Again, there is a toughened and indurated condition of the walls of the fistulous tract; the ligature, of course, cuts through the top portion of this, leaving the bottom untouched. Mr. Salmon often said that if the bottom of a long-standing fistula was not divided it would be impossible to establish the healing process. He was therefore in the habit of drawing his knife across the bottom of the sinus, and it is known at St. Marks to-day as the "back cut" of Mr. Salmon. I say, therefore, that there are four conditions, either one of which, if existing, should prevent the use of the ligature: (1) Where more than one sinus is known to exist. (2) When the fistula is of long standing and the walls of the sinus are indurated. (3) When the general appearance of the parts indicates a flabby condition which would cause the edges of the wound to be a source of irritation. (4) In cases of horseshoe fistulæ the ligature should never be used.

It was an old method to try and heal fistulous tracts by injecting different agents into them. Iodine, carbolic acid, nitrate silver, etc., have been used for this purpose. With modern surgeons the plan is nearly obsolete. A proper gauge can not be put upon the agent used. If too little inflammation is excited, no good is done; if too much, great damage may result. One effect in the hands of the charlatan has been the healing of the external opening of the fistula, and the convincing argument made to the patient that a cure was made. In a short time the patient finds himself in a worse condition than ever, because of the confinement of the pus.

There are other methods of cure for fistulæ in ano which I will not take your time

to discuss, but rather confine myself to the consideration of two operative means which I have practiced lately, and are worthy, I think, of consideration. Some months ago some surgeon of distinction in the United States reported several cases of fistula that he had operated on and had secured union by first intention. The operations were done under antiseptic precautions, and the cut edges brought into apposition. I have reported five cases so operated on to the local societies in Louisville, four in which the success was perfect; in one the wound refused to heal.

I suppose the originator of the plan (I regret that I can not recall his name) would admit that the method can be applied to only a few selected cases. If much cutting has to be done, as in the case of many sinuses, or if cavities exist, it would be impossible to get apposition, hence the operation would be impracticable. I have taken from my record book the last case operated on in this manner.

CASE: Dr. M. had an external fistulous opening about five inches up the back, a little left of the sacrum. The sinus ran down toward the coccyx, and, dipping over it, entered the rectum by the lower edge of the sphincter muscle. Examining carefully for indurations that would indicate other channels, and finding none, I freely divided the whole sinus, scraped the bottom with a small scoop, drew the parts firmly together by the use of both superficial and deep sutures, sprinkled freely with iodoform, and, spreading the gauze over the parts, applied the bandage, which I did not disturb for ten days. At the expiration of ten days I removed all dressing, and found the wound entirely healed. I shall continue to use this method in the selected cases that I have indicated, and believe that much credit is due the surgeon that recommended the plan.

Several years ago I read a paper before the Kentucky State Medical Society, suggesting what I was pleased to call "A new operation for fistula in ano." It was described in the following words: "The plan

is this: Taking the ordinary exploring probe, it is inserted into the external orifice of the fistula to determine, if possible, that only one sinus exists. Being satisfied of this fact, I then take a long slender laminaria tent and push it gently into the fistulous sinus to the fullest extent it will go. This is allowed to remain for several hours, keeping the patient under observation during the interim, at the end of which time it is withdrawn. The procedure causes but little if any pain. The laminaria tent is preferable to sponge, for the reason that it furnishes its own moisture, which assists in its withdrawal. After this dilatation I take a urethrotome with small point; closing the instrument tightly, it is pushed gently as far into the sinus as it will go, and then, by the aid of the screw attachment, dilate the sinus. When this is done, the turning of the screw at the site of the instrument will cause the concealed knife to protrude at the distal end according to the measurement desired. The instrument is then carefully withdrawn, cutting through the wall of the sinus throughout its whole length. The cut, as will be perceived, has been made subcutaneously, and the pain is insignificant. What hemorrhage takes place is easily controlled by pressure. In several instances I have turned the instrument and reinserted, practicing the same procedure upon the opposite side at one sitting. If this is not thought advisable, the patient is allowed to go for several days before repeating the operation, which is to include the other side. The advantages that I claim for the operation are, viz: Over the injection plan it must take precedence for the reason as above stated, that the injection of any agent that is commonly used for such purposes does not accomplish what is desired. The sinus is lined by a thick membrane, which will in many cases resist the action of acid agents; hence it is impossible to get healthy granulations. With this instrument both the top and the bottom, or each side, if necessary, can be cut through, thereby securing a good granulating surface, and this too without pain. Over the ligature either classic

or non-elastic, it possesses the advantage of cutting through both top and bottom, or each side of this thick membranous sinus, while the ligature can not possibly go through any portion but the top of the sinus as it cuts its way out, leaving, of course, the callous bottom, which in many cases would refuse to heal, it being a positive rule in surgery, in the operation for fistula established by Mr. Simon, that the bottom of all these tracts must be divided to insure a cure. Again, in using the ligature, the sphincter muscle or muscles must of necessity be cut through by the ligature if the internal opening be above them. In the operation with the instrument the muscle is not divided or interfered with. Over the knife it can be claimed, (1) That this operation dissipates all horror in those patients that dread the knife; (2) that excessive hemorrhage is avoided; (3) the sphincter muscles are not cut; (4) the patient is not confined to bed or taken from business; (5) the tissues are not cut.

In the majority of cases which I have treated by this method I have done so without them knowing that any thing in the nature of an operation had been done. Exhibiting the instrument to them, the knife being concealed in its case, they have never known other than that it was a probe. If I find, after waiting a few days, that a sufficient depth was not reached, the instrument is again inserted and the same procedure practiced. The patient is kept under observation a sufficient length of time to be assured of a perfect cure. Where pus cavities are found or many sinuses exist, of course this operation is not advised, but in the selected cases mentioned I am sure that the advantages claimed for it will be realized. A score of cases in my practice attest its value.

I encountered many disadvantages in operating upon the fistulous tract with the urethrotome: (1) It was too large to enter the orifice of the sinus, and recourse was had to the laminaria tent; (2) it only cut upon one side, hence required a second introduction to effect a division of both the

top and bottom of the so-called pyogenic membrane. To meet these difficulties I had Tafel make for me a modest little instrument, which I present for your consideration, and which, for a better name, I call a fistulatome. You will observe that it is very small, but little longer than a good sized probe. It has within it two concealed knives. It is probe-pointed, hence easy of introduction. In the end is an eyelet which I sometimes thread with a filiform, the object being to search out or enter any small branch that may exist when the instrument is pushed to the very bottom by the screw arrangement at the distal end. Both knives are uncovered at once. They are of sufficient length to cut entirely through the indurated membrane as the instrument is withdrawn. Patients very seldom complain of any pain. In a few cases I have injected mur. cocaine into the sinus, and then done the operation. I shall recite only one case out of many so operated on.

CASE: Mr. B., a mechanic referred by Dr. Anderson. After an extensive fistula with a number of branches had been laid open and all wounds had healed, I discovered, by examining, that a small orifice existed at the original site. Introducing a probe, I found that it entered, fully six inches, a superficial sinus that I had evidently overlooked in the operation. The fistulatome was introduced, the knives uncovered, and the instrument withdrawn. A little bleeding occurred, some soreness was complained of, and at the end of a week no sinus could be discovered. I want to be explicit in saying that the cases in which this little instrument will prove of service are limited, and yet I do believe that any fistula that could be cured by the ligature, elastic or non-elastic, can be cured, for reasons already named, by this instrument, and that it will be found of more service than some other methods that have been recommended. I am now having an instrument made of the same size and after the same device, which carries four knives instead of two. It has occurred to me that the freer the division of the walls the more satisfactory would be the result.

LOUISVILLE.

## IS SENN'S GAS TEST INFALLIBLE AND ALWAYS DEVOID OF DANGER?\*

### Two Cases of Shot Wounds—Conclusions.

BY H. C. DALTON, M. D.

*Superintendent City Hospital, St. Louis.*

I report to-day one case of laparotomy for shot wound, and another in which an operation ought to have been performed, and would have been, had I not been deterred on account of the failure of the Senn method, being led thereby to believe that the intestines were intact. It is not always pleasant to report our failures, but believing it a duty we owe the profession in order that our statistics may be reliable, I have made it a rule to report all my failures as well as successes in abdominal surgery.

It is true this course may subject me to criticism, owing to some sins of omission or commission, but, as criticism will teach me wherein I have erred, I shall still be the gainer. Should the criticism be unjust, I trust it will proceed from him only who has never made a mistake in surgery. This apologetic prelude is written to induce you to "be to my faults a little blind" when you listen to the "o'er true tale" of the two following cases:

**CASE 1.** B. J., colored, aged thirty-five, laborer, admitted to the hospital October 25, 1888, was shot at a distance of twelve or fifteen yards three hours before admission, after which he was unable to walk, and soon felt a numb, dead sensation in the right leg, followed by pain in the abdomen.

Examination showed a shot wound an inch and a half above, and a little to the right of the anus, the probe passing upward and inward through the great sciatic notch into the pelvic cavity. The urine was drawn and found to be clear. There was absence of liver dullness to the extent of two inches above the border of the ribs. The patient was suffering from shock and intense pain in the abdomen, referred to the umbilicus. The extremities were cold; pulse 72, and respiration 39; rectal temperature 96.6° F.

Assisted by Drs. Meisenbach and N. B.

\*Read before the Mississippi Valley Medical Association, at Evansville, Ind., September 11, 1889.

Carson and the hospital staff, I intended to make median laparotomy, using Senn's hydrogen gas test before making the incision. A small hole was made about two inches below the umbilicus, a glass tube was put in and an unsuccessful attempt was made to ignite the gas. When the tube was removed the gas escaped through the hole and ignited readily. Upon enlarging the wound the gas escaped with an audible sound. The bullet was found to have entered to the right of and almost grazing the iliac vessels. It then entered the cecum a little to the inner side of the appendix, and passed out an inch and a half above. Twelve holes were closed by the interrupted Lembert suture, freely-d still being next—two in the cecum (as described above), six in the small intestine, three in the mesentery, and one (the hole of entrance) near the iliac vessels. The bullet was not found, nor were we able to find it *post-mortem*.

After a thorough peritoneal toilet we attempted to return the enormously gaseous, distended intestines, but found that, like Banquo's ghost, they would not down. It seemed our task was like that of Sisyphus, for as fast as we would replace one coil another would "bob up severely" from below, until our patience, as well as our patient, was well-nigh exhausted. To make confusion worse confounded, about this time, when we thought our task almost completed, the intestines being nearly all reduced, two or three sutures gave way and the cavity was again flooded with fecal matter. In the attempt to reduce them the intestines were necessarily subjected to rather rough handling and considerable pressure, hence the rupture. The sutures which gave way were those closing two holes which were very close together, and we found it difficult to locate the exact spot from which the feces escaped. We accomplished it, however, by a very simple, but I think important, method suggested by Dr. Carson, that is, allowing water from the irrigator to play upon the part while making pressure upon other side of the holes. The escape of the gas elevated the water to perhaps a half inch, indicating

the exact site of rupture. An attempt was made to get rid of the gas by washing out the stomach, and putting a cylindrical speculum into the rectum to facilitate the escape of the gas, but this much-vaunted method failed utterly.

Here was a case where the Senn method not only did no good, but absolutely did a great deal of harm. But more anon! The case also teaches a valuable lesson, in that it should caution us, no matter how far away the wound of entrance may be, to look out for abdominal injury if the range of the bullet be in that direction. In a conversation with Dr. Senn, some weeks ago, I informed him of the above facts. He stated that he had also been annoyed by the same thing, but it could be overcome by elevating the hips and using a large funnel-shaped towel to produce compression upon the intestines during their reduction. I do not believe that it would have worked in this case.

CASE 2. Wong Gau, Chinaman, aged twenty-five, laundryman, entered the hospital at 7:25 P. M., October 11, 1888. One hour before admission he was shot by a negro at a distance of ten feet, the bullet entering between the fourth and fifth ribs in the left axillary line.

The assistant who examined him (I was absent at the time) probed the wound, and concluded that it did not penetrate the abdominal cavity, a very natural mistake, as there were no symptoms pointing in that direction, except that he had vomited several times, the ejecta, however, containing no blood. When I returned to the hospital, three hours after the injury, the pulse had gone up to 100; temperature 100°F.; but there was still entire absence of abdominal symptoms.

Suspecting, however, from the direction of the bullet, that it had penetrated the cavity, I resected two inches of the seventh rib in order to inspect the diaphragm. A hole was found in the same about three inches from the thoracic wall. Through this hole I placed a glass tube and applied the hydrogen-gas test, which gave negative results,

although the tube was moved in various directions, and removed several times to see if it was unobstructed. The urine was drawn and found to be clear.

Having great faith in the gas test, I was satisfied that the alimentary canal was intact. My faith has received several rude shocks, and I am no longer an enthusiastic advocate of the measure except in certain cases.

The diaphragmatic and thoracic wounds were closed with heavy chromotized catgut. Patient died twenty-eight hours after the injury.

The autopsy revealed two holes in the stomach and a large lacerated wound of the left kidney. The holes were on the greater curvature, three or four inches below the cardia. They were quite close together (half an inch of septum), each hole being about half an inch in diameter. The stomach was one third full of semi-solid food, mostly rice, the consistence of which was so firm that it failed to run out when the stomach was elevated, nor did any escape *antemortem*. The food plugging up the holes and overlying them accounts for the failure of the gas to escape. It naturally sought the higher and unobstructed portion of the stomach, and by its pressure plugged up the holes still more securely.

During anesthesia the patient came near dying from interference with respiration, due to the great gaseous pressure on the diaphragm. Had there not been large gaseous eructations, partially relieving the pressure, I believe he would have died upon the table. The case teaches that extreme care should be taken in giving the anesthetic during the gas test. It also teaches that the test is liable to deceive us at a very important juncture, and that we can not positively depend upon it in gunshot wounds.

In the above case I might have turned the patient on the right side, allowing the food to gravitate to the right, leaving the holes free for the exit of the gas. But who would have suspected such a condition as we found in the case, or would have thought of the necessity of placing the patient in such va-

rious positions? It is certainly unusual to have a patient with both stomach and kidney so badly injured without some blood being vomited or being found in the urine, and this assisted the Senn test to deceive us in the case. I object to the use of the gas test in shot wounds for the following reasons:

1. Because it is misleading, not being *always* reliable.

2. Because, even if it give negative results, we should operate any way, as we are not sure that the intestines are not perforated, and statistics give but poor encouragement to those who adopt the denothing plan, the recoveries in such cases being less than eight per cent.

3. Because, even were we positive the intestines were uninjured, there are other organs which are almost equally important, such as the liver, spleen, mesentery, etc., which might require prompt attention.

4. Because I believe there is danger of the gas forcing feces through the wounds into the peritoneal cavity, thereby adding to the gravity of the case. It is said this does not take place, but I am loth to believe it.

5. Because of the additional danger during anesthesia from interference with respiration.

6. Because of the liability of the sutured holes to be torn open while handling the intestines, especially during the effort to return them to the peritoneal cavity, as in Case 1.

7. Because, after their return to the cavity, owing to their distended condition and the consequent pressure upon the diaphragm, it embarrasses respiration, *and hence adds to the shock*. I believe this to be a valid and most serious objection to its use. He who can put his patient to bed with the least shock, *ceteris paribus*, has the best chance of seeing him recover, for shock is the cause of death in the vast majority of cases, and certainly the liability to death during anesthesia, while not probable, is more likely to occur with the use of the gas than without it, and hence should be taken into account.

Those who have attempted to close the abdomen over intestines distended by gas can fully appreciate my statement. I imagine that a well person with intestines so distended would suffer from colic and a feeling of oppression consequent upon the great gaseous distension. Why should we add such additional danger to our patient, already in such a perilous condition, when a feather's weight may turn the scale against him? It may be claimed, and I grant it, that the gas soon becomes absorbed, but why subject a patient to an additional risk, even for a short time, at such a critical period? Thus, too, the preparation and administration of the gas takes up valuable time; it is true, not a great deal of time, but when one remembers that the saving of every moment in these cases is vitally important, he naturally is anxious to get through at the earliest possible moment consistent with the proper management of the case.

Senn reports a case of shot wound of the intestines in which, after sewing up all the holes he could discover, he was enabled by the use of the gas to find another, low down in the rectum, which he could not have found without it. I imagine such cases are very rare, and do not counterbalance the harm which the gas may do in other directions. I would not leave the inference that I have discarded the gas test. I would use it in shot wounds of the back, and low down on the sides of the abdomen, where I could not positively determine whether or not the peritoneal cavity had been penetrated. In other words, where we are in doubt as to the penetration, use it, and if we get affirmative results, operate. I think the test is more appropriate to stab wounds, for here we are often very much in doubt as to whether or not the intestines are wounded. When we are so uncertain we should use the gas test; if it give negative results we need not operate, especially as we know that many penetrating stab wounds do not wound the intestines, whereas it is quite the exception, in fact a *very rare* occurrence, for a penetrating shot wound to fail to do so.

So I conclude that the fact that a shot

wound of the abdomen is penetrating justifies laparotomy; for, unless the ball be a spent one (a very unlikely occurrence), we can be almost certain that there is serious injury to the viscera. This is a rule to which the exceptions are too few to have any weight.

The gas test then in this class of cases is unnecessary. In penetrating incised wounds, however, the character of the injury is such that the viscera may, and in fact often do, escape.

I believe that this question should be thoroughly discussed and the truth evolved, not only for the good of our patient, but also for the medico-legal aspect of the case. Self-protection demands that the status of the test be definitely settled. I have not been able to find that any one has controverted Dr. Senn's claim that "rectal insufflation of hydrogen gas is an *infallible* test in the diagnosis of visceral injury of the gastro-intestinal canal in penetrating wounds of the abdomen." My experience will not allow me to subscribe to the statement.

I propound the query: Is the question settled? and answer in the negative, believing it to be still *sub judice*. What say you after thoroughly weighing the facts in the above cases?

ST. LOUIS, MO.

### CONTAGIOUSNESS OF TUBERCULOSIS.\*

BY WILLIAM PORTER, M. D.

*Chairman of a Committee appointed to report to the Mississippi Valley Medical Association at Evansville, Ind., 1889.*

A year ago, when I was appointed a member of the committee to report upon the Contagiousness of Tuberculosis, I fully expected to be able to present to you a condensation of all the writings upon this subject to date.

Those of you who have noted the current medical literature for the last twelve months will agree that such a purpose could not be now carried out in the time to which our papers are wisely limited.

Moreover, I believe that a free discussion

of this subject will profit more than the presenting of even the most exhaustive report; therefore I will not embarrass the former by attempting the latter.

The choice of the term "contagious" is not a happy one, and yet it has a conventional meaning well understood. I shall here use it as meaning transmissibility. The word "portagious" suggests a thought which should always be kept in mind in our care of phthisical cases, which is that tuberculosis is a disease that can be carried; that the specific elements are portable. This, if we were to hold to the exact use of scientific terms, is more accurately descriptive of that feature of tuberculosis under discussion than is the word "contagious." Let us to-day, however, employ these terms as expressing the same idea, and thus avoid confusion and misunderstanding.

The careful reader of to-day can not but notice the almost entire unanimity of opinion as to the possibility of the contagiousness of tubercular disease, and it is not so much to argue this proposition as to speak of the manner of transmission that I will claim your attention.

In all experiments made to determine the transmissibility of tubercle it is well to accept the presence of the "tubercle bacillus" as a definite proof of the existence of tubercle. As I have elsewhere said, I am not fully convinced that it is always the cause, or, as many able writers say, the only cause; but even this may some time be demonstrated. At present (and I think this will suffice for our purpose to-day) I believe that if the bacillus is not the cause of tuberculosis it is at least the result.

The causative relation of the bacillus to tuberculosis is not, however, our theme, and, lest we fall into profitless discussion by the wayside, permit me to return to the subject proper, the question of contagion.

At the outset we are met with the question: Can tuberculosis be directly inherited? or to state it more plainly, can a new-born child have in its tissues bacilli transmitted directly from the father or mother?

We all will admit that a child may inherit

\* Read before the Mississippi Valley Medical Association, September, 1889.

a particular conformation of chest, or a constitutional predisposition which may favor in after years the development of conditions favorable to tubercular invasion; but whether the fetus may be infected through the ovum or spermatozoa is doubtful, though such infection may probably be accomplished through the placental circulation.

Johns claims to have proved placental infection to exist in the cow, and Baumgarten, as well as some others, affirm that a child may be born with bacilli tuberculosis in its tissues, which may remain latent for years, or even during the life time. Landouzy and Martin have caused tuberculosis by inoculating animals with the placenta of tuberculous patients.

There is considerable evidence, therefore, to show that tubercle may be directly inherited from the mother, but never from the father. And the great probability is that instances of direct inheritance of tubercle are very rare indeed.

One such instance, however, was in my own practice during the past year. A lady patient far advanced in pulmonary tuberculosis gave birth to a child which died in seven months with well-defined tubercular disease.

Leaving the solution of the problem of direct inheritance of tubercle to the future, let me offer two propositions which I believe are susceptible of demonstration, and, if so, are of the greatest practical value in their relation to human life:

1. The products of tubercular disease may be carried from a diseased human subject to one apparently healthy, in whom, as the result of such transmission, all of the well-known processes of tuberculosis may follow. In such cases the respiratory tract is generally primarily affected.

2. Through the media of meat and milk tuberculosis may be transmitted from diseased animals to man. In these cases the alimentary tract is first invaded.

Other methods of transmission are recognized by leading investigators; but these two, being the most important, will fully occupy our time.

The proposition that tubercular products from a diseased individual may be engrafted upon and infect a non-tuberculous subject through the respiratory tract is not only of the greatest interest, but of first importance.

I need not refer to many of the numerous experiments that have been made upon animals to determine the possibility of acquiring tuberculosis through inhalation of air loaded with particles of diseased matter. The researches of Virchow and Chauveau, twenty years ago, were demonstrations of the fact that tubercle could be conveyed by inoculation. The objection made by Sander-son and Fox, that tubercular conditions could be produced by inoculation with non-tubercular material has, I think, been well answered by Martin, of Paris, who, from numerous experiments, concludes that after inoculation with tubercular matter general tuberculosis may be produced, and the virus acquires increased potency when inoculations are made in series of animals of the same species. On the other hand, the inoculation of non-tuberculous matter may produce tubercles which, however, do not, when inoculated, give rise to general tuberculosis, and this virus, after several terms of the series, seems to lose the power of causing even a characteristic local inflammation.

If we accept as true the statement that tuberculosis may be conveyed by inoculation, we are prepared to receive the further statement that it may be transmitted by the inhalation of the products of the disease. There is ground for the belief that many of the instances of acute infectious diseases which have their gravest manifestations in the air-passages are cases of inoculation; in diphtheria, for instance, where the mucous membrane, denuded of its epithelium, becomes a suitable place for the reception and propagation of the specific germ, or in erysipelas of the upper air passages, where probably a similar phenomenon takes place, and possibly in scarlet fever, and as some European writers think, in cases of specific pneumonia.

What is the evidence to warrant us in concluding that tuberculosis may be contracted in this way?

First: The experiments upon animals by Tappeiner in 1883, who found seventeen tuberculous animals out of eighteen that had been made to inhale tuberculous sputa; then the results of Koch's trials, who found within twenty-eight days tubercles in the lungs of guinea-pigs that had been made to inhale material from phthisical cavities.

The experiments conducted by Cadeac and Mullet showed that while the expired air from tubercular gave negative results, the inhalation of air which contained particles of dried sputa from the same patients produced tubercle in two out of twelve of the guinea-pigs employed.

Some experiments of my own (Portagiousness of Phthisis, *Journal American Medical Association*, March 1, 1888), which need not be given in detail, showed that where tuberculosis was produced in a guinea-pig by inoculation, it was possible to infect a previously healthy animal by causing it to inhale the air from a close box in which the diseased one was confined.

When we come to a practical study of tuberculosis in the human subject, the evidence of its transmissibility is, I think, conclusive. I need not here detain you by citing individual cases in proof of this assertion, for probably each of us will remember instances where, if there was not actual demonstration of the contagion of tuberculosis, there was at least circumstantial evidence strong enough to deeply impress us.

Aggregated investigations are always more valuable than isolated instances. We find that the Collective Investigation Committee of London received replies to inquiries from two hundred and sixty-one physicians in active family practice, affirming the proposition that phthisis may be communicated from the sick to the well. In these answers many cases were related which seemed to leave little room for doubt.

In this country the pathologists of the New York Board of Health have even gone so far as to distribute published rules for the prevention of consumption, based upon the knowledge of its contagious nature.

At a meeting of the Paris Academy of

Medicine M. Villemin read a report of the special committee appointed by the Congress for the study of tuberculosis last year, which it was proposed to publish, with the object of instructing the laity as to the nature of the disease, and the best means of avoiding contagion. The report calls attention to the fact that pulmonary phthisis is not the only form in which tuberculosis manifests itself, but that many cases of pleurisy, peritonitis, meningitis, and bone and joint diseases are often tuberculous. The report insists upon the contagiousness of the disease, and refers to the various ways in which the bacillus may gain entrance into the body. Since the sputa of phthisical patients usually contain the bacilli in large numbers, special care should be paid to the immediate destruction of all expectorated matters.

In a paper by Dr. J. E. Squire, before a recent meeting of the London Epidemiological Society, the statement was boldly made that the discovery of the bacillus tuberculosis allows us to place phthisis in close relation to the class of infectious diseases, toward the control of which preventive medicine has already done so much.

Dr. Cornet, in an excellent paper read before the Berlin Medical Society, only voiced the opinion of many other writers when he said the chief danger of contracting phthisis by contagion lies in the dried sputum, which is often turned into respirable dust.

Dr. Lawrence Flick, in a paper read before the Pennsylvania Medical Society last year, says "contagious diseases are dependent upon a diseased germ, and can not be contracted except through the medium of that diseased germ. Every case is dependent upon some other case, and no case can spring up of itself." He then endeavors to show, by a careful topographical study of phthisis in the Fifth Ward of the city of Philadelphia for a period of twenty-five years, that consumption observes this law.

Few physicians are ready to accept such advanced views as these, and yet a careful study of Dr. Flick's essay will show good grounds for his assumption.

Objectors to the doctrine of the contagion of phthisis often quote the statistics of the Brompton Consumptive Hospital, which show the fact that the medical attendants and nurses at this famous institution have been singularly free from tuberculosis.

Instead of arguments against the probability of contagion, are not these facts, of which you are all aware, evidences of the value of prevention? Where could we find better hygienic conditions than in such a hospital? and it is to just such conditions that the advocates of contagion look for relief. If the fact that the resident physicians and nurses at the Brompton Hospital seldom become victims of tuberculosis is a proof of the non-contagiousness of the disease, then by the same process of reasoning can we prove that diphtheria, erysipelas, and even cholera, are not contagious.

A most interesting fact in keeping with the idea of the transmissibility of phthisis is that localities once famous for freedom from tubercular disease may in time acquire a doubtful reputation as health resorts for phthisical patients.

Dr. Benjamin Rush wrote that consumption was unknown among the North American Indians in the early history of the country, and very infrequent among the early settlers of New England. A hundred years ago the climate of New York was thought to be curative in cases which had acquired phthisis in the Old World. Afterward the level prairies of Illinois, and since then the mountains of Colorado and the salubrious atmosphere of California have been the Eldorados of the victim of tuberculosis.

That there is much in the curative influence of climate I firmly believe; but the point I wish here to make in accord with the idea that tubercle is transmissible is, that a place or a people once free from the ravages of tuberculosis may, by being brought into association with tuberculosis and by ignoring sanitary precautions, acquire conditions recital for the spread of the disease.

I wish to emphasize the idea that when a certain locality becomes famous as a resort

for consumptives, the strictest care should be taken by those in authority to enforce all that is now known of sanitary and hygienic laws to prevent possible transmission of the products of the disease. Who has not seen moccasins left by the victim of tuberculosis slowly drying on the grass or gravel in front of the summer hotel, needing only time and a gentle breeze to be wafted in broken doses, possibly even into the sleeping chamber of the unconscious and the unguarded. We vent our indignation upon the unlucky wight who drops the orange rind or banana peeling upon the sidewalk, but fail to notice him who himself the victim of the dread disease, unconsciously or ignorantly places a greater danger in his neighbor's pathway.

The statement has been made by Flick and others that patients with phthisis have greater immunity from other contagious diseases. Dr. Welch says that, having seen upward of five thousand cases of smallpox at the Philadelphia Municipal Hospital, he does not remember one who had well-marked phthisis. Dr. Longstreth, Pathologist to the Pennsylvania Hospital, in twenty years has never found consumption in an autopsy for typhoid fever.

Thus it appears that the study of tuberculosis as a contagious disease is each year presenting new and interesting conclusions, and certainly we have reason to hope that the line of investigation so largely directed by Koch's discovery may ere long bring about results which will be of greater practical advantage than any with which we are now familiar.

**Second:** Having gone somewhat hurriedly over the grounds upon which are founded the theory of the transmission of tuberculosis from man to man, let us see what reason there is to believe that it can be carried from animals to man.

You are all familiar with the unanimous conclusions of the Congress on Tuberculosis, held last year in Paris, which was in support of the idea that tuberculosis is contagious and that there is positive danger to the human race from the consumption of the

milk and flesh of tuberculous animals. It was proven by numerous experiments that animals fed upon diseased meat were exceedingly liable to become tubercular, and then it was demonstrated by Carmil, who had made a special study of the subject, that the tubercular bacillus as found in such animals may penetrate the unbroken mucous membrane of the respiratory and intestinal tracts.

M. Moule and also M. Cagny had observed that domestic fowls were often the subjects of tuberculosis, the disease being found first in the abdominal organs. This I believe to be a most timely warning against a danger next to that of bovine infection. Some of you may have seen the barn-yard fowl destined for early enrollment on the menu card picking over the debris from tuberculous patients who have been attracted by the well-known reputation of the place for good water, pure air, and the best of food. It is not pleasant to think of such things, but unless we think of them we can not remedy them.

A learned paper by an honored member of this Association, Dr. J. A. Ouchterlony, was read before the Kentucky State Medical Society, in which he expressed his conviction that there could be no security from tuberculosis so long as tuberculous meat and milk are used. "The disease is contagious, infectious, and not congenital. It is transmissible, especially through the alimentary canal and respiratory tract. Rabbits kept near tuberculous patients contract the disease in twenty-seven days. Rabbits suspended in cages so as to breathe the air exhaled by tuberculous cattle contract tuberculosis. The lungs are the primary seat of the infection. It may be contracted through the integument, mucous membrane, abraded epidermis, wounded and abraded surfaces. Tuberculosis in dumb animals is identical with tuberculosis in man. Transmissibility to other species is very frequent."

In a recent paper on the Communicability of Tubercle through Cow's Milk, Dr. Louis Parkes, of the University College, London, says: "While not denying that the tubercular virus may find other means of

reaching the digestive tract than through unboiled cow's milk, it appears to me that there are no sufficient safeguards in the management of town dairies to warrant us in assuming that milk from cows in an advanced stage of tuberculosis has no chance of being mixed with the milk of other healthy cows. In every dairy of any size there will probably be tubercular cows, some of them, perhaps, with tubercular deposits in the udders; and as it is the common custom with dairymen to mix together the milk yielded by different cows, it is not too much to assume that tubercle bacilli may be widely distributed in the milk supply of any town. It has been said that the tuberculosis of cattle is not the same disease as the tuberculosis of man, and that the absence of any proof of the human variety having ever been dependent upon ingestion or inoculation of the virus of the bovine variety tends to strengthen that belief. To this it may be replied that the bacilli of bovine tuberculosis are identical, according to all bacteriological methods at present known, with those found in tubercular formations in the organs of man, and that, although the disease presents anatomical differences in man and cattle, these differences may be explained as being due to differences of soil in the human and bovine tissues, the bacilli ingrafting themselves in those tissues which present conditions most favorable to their growth and development. Secondly, absence of proof may only mean want of observation or recorded data, and can not be held to imply that at no future time will satisfactory evidence of the dependence of the human disease upon a bovine source be brought to light."

If time did permit I would quote at length from the paper of Dr. Paul Paguin, presented at the Missouri State Medical Society last May. He asserts that "the milk of tuberculous cows, especially those having lesions in the mammary glands—a common thing in grave cases, by the way—has been found by Degive, Bouly, and Nocard, of France, Bollinger in Germany, Bang in Sweden, Harsten in Belgium, Lydtin in

Switzerland, Fleming in England, and a few American pathologists, to be capable of producing tuberculosis. I myself have found extensive tuberculous lesions in the mammary glands of milch cows, and I have known of some cases of tuberculosis induced by bacillized milk."

The important question for us as physicians is, can the danger of transmission be averted? So far as our present knowledge goes we might answer, not entirely; but if there be value in the carefully formed conclusions made from the scientific work of the last decade, much may be done to limit the number of victims of tuberculosis. We may not all be ready to fully indorse the statements authorized by the New York Board of Health, that tuberculosis is a distinct disease, that it is not directly inherited, and that it is acquired by direct transmission of the tubercle bacillus from the sick to the healthy, usually by means of the dried and pulverized sputum floating as dust in the air. For myself, I am convinced that in this direction is the safest path, and as no harm can come from excessive care regarding food and sanitation, I am willing to advise such care, though it seem to be excessive.

From experiments made upon animals and observations upon the human species, it is plain that much of the danger of contracting tuberculosis lies in the inhalation of air loaded with tuberculous sputa. Surely the danger can, to a large extent, be met by insisting that tuberculous patients should, as far as possible, use a cuspidor in which is a solution of bichloride of mercury at least 1 to 1,000, for it has been demonstrated that the bacillus can live in solutions of less potency.

Cuspidors and cloths which are used to receive the expectorated material from diseased lungs should, as far as possible, be kept moist, and the bed-clothing thoroughly freed from all power of contamination. There is nothing which demands correction more than the uncleanly and unsafe practice which many follow who have care of consumptive patients, of placing newspapers

on the floor by the bedside upon which the expectorated masses are gathered and dried for free distribution in the household.

The careful disinfection of the room which a tuberculous patient has occupied is a matter of detail not to be overlooked by the medical attendant.

So far as protecting the public against food containing tubercular products is concerned, it can only be accomplished by thorough inspection. It is certainly the duty of each physician who is himself satisfied that such danger exists to endeavor to impress the public mind with the importance of proper legislation upon this subject.

If we are convinced that tuberculosis is contagious and will but work up to our convictions, it is possible that the first step will then be taken to place this much dreaded disease under the same treatment as is smallpox and the once all-destroying plague.

Although none of us may be willing to ignore the agency of individual tendency, physical formation, and other conditions as predisposing factors in the causation of tuberculosis, yet, as we get away from the idea of heredity and approach the more tangible view of transmission, the future is brighter with promise, and will, I have no doubt, be more abundant in practical result.

ST. LOUIS, Mo.

## Reviews and Bibliography.

**Annual of the Universal Medical Sciences.** A Yearly Report of the Progress of the General Scientific Sciences Throughout the World. Edited by CHARLES E. SMITH, M.D., and twenty associate editors, assisted by over one hundred corresponding editors, collaborators, and correspondents. Illustrated with chromolithographs, engravings, and maps. Five volumes. Price, \$15. F. A. Davis Publishers, Philadelphia, New York, and London, 1889.

In the annual address prepared by Austin Flint for delivery before the British Medical Association, the distinguished author dwelt upon the necessity for brevity and perspicuity in medical writing, and especially in journalistic work.

No suggestion could have been more timely, nor, as to the average writer, more futile. The custom of too many writers is to conclude that it is incumbent upon them, when writing a medical article, to go back and collate the text-books for the names of original workers in the particular line taken up, and thus in each instance tax the patience of the reader to go over again what he has too often had to go over before. Besides, there are thousands who write (and excusably) for their own benefit, and write things which are new only to medical students. To reach this class of people and educate them up to the standard laid down by Flint was a task to be accomplished only in the centuries following the millenium.

The next thing to it was to enlarge on the idea of Schmidt's *Yahrbücher*, Braithwaite's *Retrospect*, and other similar publications, and give each year, in a series of volumes, all valuable items of progress and discovery to be found in the medical journals of the world. And to the credit of the *Annual of the Universal Medical Sciences* it may be said that it has more nearly attained this object than any other publication ever issued in any country.

Here we have really all that is most valuable gathered by competent workers from all the annual medical literature of the world, and presented in such shape as to be easily conned in a few weeks, and read through in a couple of months.

There seems to be still room for improvement, if in nothing more than in establishing in some way the worthiness of the various writers to be quoted. This is especially the case in therapeutics. Each writer appears to have met with success in his cases with some particular treatment, while if he tried others, such as other writers had met only success with, he has found them useless. The writers in therapeutics who deserve to be given our time are comparatively few; they must be men of learning, of clear, logical powers, who can divest themselves of biasing interests, and men who walk by fact and not by faith. The great advance here

attained gives earnest that in the near future rigorous tests will be applied to results, and the practice of medicine be lifted more completely from the slough of blind empiricism.

D. T. S.

Relative to this publication Dr. E. S. McKee says:

"This series of five volumes, full of meat, is again before us. The series of 1888 was good, remarkably so for a first attempt, and was highly appreciated by all who possessed themselves of it. The *Annual* for 1889 is, in as many ways as possible, an improvement on its predecessor. Several new features are added to facilitate research. To each reference is added the date, and number or volume of journal quoted. By a system of double checking each reference has been verified, thus making them as reliable as possible. Grams are reduced to ounces, drams, grains, etc., and the centigrade and Reaumur thermometric measurements to Fahrenheit. Both appear side by side. To render the perusal of the books more agreeable to the many foreign subscribers counter reductions are made. A complete and compact index is given to each volume in addition to the remarkable triplex index of the entire work at the end of the last volume, as in 1888. The idea of the work is to present the very best of all, and in the best manner possible. How well the compilers have succeeded will be learned on purchasing and perusing the books."

## Correspondence.

### LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

A correspondent of Dr. Richardson has been endeavoring to put what is called "a poser" to that distinguished apostle of temperance. He would be glad to know whether, "in spite of temperance proclivities," Dr. Richardson adheres to the rule that it is good to administer a dose of alcohol before proceeding to administer chloroform. The reply is to the effect that abstinence from the habitual use of alcoholic

beverages has nothing to do with the scientific administration of alcohol in the form of a remedy. "A physician," it is added, "or a surgeon, because he administers chloroform, need not therefore be himself habituated to chloroform as a narcotic fluid; and, as what is consistent with regard to one narcotic is equally consistent and true in regard to another, the most rigid abstainer may with all propriety employ alcohol as a means of cure, provided that he do not so use it as to make it a cause of permanent evil." Dr. Richardson goes on to say that no wise and prudent administrator would think of administering alcohol to young children; neither would he administer it to women of calm and placid disposition who are free of tears, and to whom a stimulant is objectionable; but he admits that there are persons to whom the dose of alcohol may be a remedy.

The hypnotic treatment of chorea appears to give better results than any other. The patient is so subjected to the influence of chloral, sulphonal, or urethane, that he sleeps heavily for from ten to sixteen hours out of the twenty-four. The effects, it is stated, have been so excellent in a number of very severe cases that the method is to be continued upon a more extensive scale. While admitting the practical advantages of the new mode of dealing with such cases, practitioners are warned to take great care that the "chloral habit" is not thereby initiated.

Cocaine and the electric current have recently been used with success in treatment of external canal and membrana tympani affections. It is called anesthesia by means of cocaine and electric cataphoresis. The procedure is to soak a piece of cotton wool in a solution of cocaine of eight to ten per cent, and, fastening it to the positive pole of the electric battery, place it upon the spot to be anesthetized, and allow it to remain thus in contact for fifteen or twenty minutes. The negative pole is placed at the same time upon the neck. By this mode of anesthesia paracentesis membrana tympani is performed, and incisions into the

walls of the auditory canal, without giving any pain to the patient. Frequently, when cocaine cataphoresis is used, the sensibility is notably reduced. It must be added that cocaine anesthesia is valuable only for operations, not for quelling pain due to inflammation.

According to the Report of the Scotch Lunacy Commissioners—that are called preliminary discharges—have been remarkably successful. The probability of allowing lunatic patients who appear to be recovering to go out and stay with friends for a while, in order to try the effect of freedom from restraint, is not wholly unknown in England. At Harwell it has long been a recognized practice to grant a trial leave to the extent of a month, but in Scotland this course has been established by law, and is carried out on a more extensive and systematic fashion. When the probationary discharge is for an more than twenty-eight days, it may be granted by the superintendent on his own authority, but previously it is found that this step is often insufficient, for the first taste of liberty with some temptations being to cause a temporary relapse. In such cases the board have power to grant a discharge for a period not exceeding one year. As regards the twenty-eight-day discharges, it is stated that the large majority of patients to whom they are granted undergo no deterioration, and none are benefited by the change. In the case of the more important discharges under the direct authority of the board, they are eminently satisfactory. The system has now been in force in Scotland for twenty-six years, during which period no fewer than 3,233 patients have been discharged in this manner, yet the instances in which it has been found necessary to replace patients in the asylums before the expiry of the period of probation have been 222 only. In the course of last year 127 such were permitted to go out exclusive of the twenty-eight-day probationers, and of these 19 have already been finally discharged as recovered, while 14 whose period of probation has expired remain under the care

of friends; 80 were still on probation at the close of the year, and 14 only had been returned to the asylums.

Pilocarpine for deafness forms the subject of communications to the *British Medical Journal* by Drs. McNaughton, Jones, Woodhouse, and H. Barrett. The last named cites four cases, three of gentlemen, aged from twenty-three to forty-five, who were benefited by the treatment, and one lady, about twenty-one, whose hearing was not materially improved. The treatment, consisting of hypodermic injections of the drug, was continued systematically during a period of six weeks, in which period the male patients recovered their hearing in a very marked and altogether satisfactory manner.

A member of the chloral family—chloral-amide—is greatly exercising the experimental powers of some practitioners just now, and the new hypnotic, which is an accretive derivative of chloral and formamide, is announced with the usual flourish of trumpets as being far superior to sulphonal, chloral hydrate, etc. From one to three grams, administered in water (which dissolves it in the proportion of about eleven per cent), causes an easy and refreshing sleep, lasting eight or nine hours. No after ill effects, it is said, need be feared, even in cases where the heart's action is feeble, while chloral-amide has no inflammatory or caustic properties. At Strasburg it was found to be successful in thirty-one cases of insomnia, but up to the present in England these good results are not confirmed.

Dr. A. W. Macfarlane is enthusiastic over infusion of senna pods as a remedy for constipation. He states that the infusion is almost free from taste and smell, and is devoid of the characteristic odor and flavor of senna. It appears to increase activity in the muscular movements of the whole gastro-intestinal canal, acting quite as much on the colon and rectum as upon the small intestine. It is slower in its action than an infusion of the leaves, but equally certain, an ordinary dose producing without fail one motion, seldom more, in from eight to ten hours, and without exciting any congestion

of the pelvic vessels or increasing or aggravating hemorrhoidal or menstrual discharges.

The second part of the fifth edition of Professor Michael Foster's *Text-book of Physiology* is on the eve of publication, as also is Mr. W. North's *Roman Fever*—an inquiry into the origin of the malarial fevers of the Roman Campagna, with special reference to their supposed connection with pathogenic organisms.

The following advertisement has just appeared in a provincial newspaper:

"WANTED.—A doctor to vaccinate a child in a hygienic manner."

LONDON, ENG., September, 1889.

## Abstracts and Selections.

**THE PREVENTION OF TUBERCULOUS DISEASE.** The conception of tuberculosis gained by the memorable discovery of the bacillus by Koch in 1881 is being rapidly pushed to its extreme logical conclusion. For it is remarkable how widespread is the acceptance of the belief, based on that discovery, that this morbid state which manifests itself in so varied a manner, according to the tissue or organ that is primarily attacked, depends upon the introduction of this parasite into the body. The disease thereby takes a definite position among the infective class, since, so far as present knowledge goes, all diseases owning an ultimate cause in an organized virus are communicable. It does not matter for the argument whether—as undoubtedly would appear to be the case with regard to tuberculous affections, and as is probably true of the whole group of specific infective disorders—the victims selected have been already predisposed by heredity, environment, or otherwise, to become a favorable soil for the growth of the parasite. This is a question which ought not to enter into the consideration of the preventive measures to be adopted, except in so far as it is necessary to secure that individuals so predisposed are placed under conditions the most favorable for the maintenance of general health. For it is conceivable that under certain transitory conditions an individual not predisposed may yield to the attack of this ubiquitous parasite. No better illustration could be given of the manner in which the bacillary doctrine of tuberculosis now dominates the scientific world than the fact that in Berlin, Paris, New York, and Glasgow there have been recently published declarations,

police regulations, reports and judicial decisions, all of which turn upon the acceptance of this doctrine as an assured fact, with the corollary affirmation of the transmissibility of the disease from man to man and from animals to man. The result is, and can only be, on the admission of this teaching as a proved scientific truth, the enforcement of prophylactic measures of the most stringent kind, such, for example, as have been widely promulgated during the past week by the Committee of the Paris Congress on Tuberculosis, constituted by many eminent men. The policy adopted is thorough enough to satisfy the most ardent hygienist; but he indeed would be sanguine who could hope to see even a tithe of these recommendations carried out in practice. For, owing to the complex conditions of civilization, to the sentiment of humanity, as well as to the affections of the family circle, it is obviously impossible to obey these harsh, if wholesome, dictates of science. In the abstract, doubtless, such recommendations are logical and reasonable; in their application to the prevalent conditions of human existence they will fail by their own impracticability. We talk of the segregation of lepers as the one efficient method for restricting the spread of that scourge of subtropical lands, and perhaps we could realize what that implies if we applied the same measures to subdue the ravages of a disease which in its extent and its fatality ranks far above leprosy. Yet, to be logical, to the one disease should be meted out the same measure as to the other, or the millennium of hygiene will never arrive.

We have stated the matter thus broadly, not because we either mistrust the evidence upon which the conclusions of the Paris Congress were based, or question the validity of these conclusions, but merely in order to point out the practical impossibility of acting upon them. Nevertheless, there are directions in which it may be possible to carry out with fair prospect of success the most rigid requirements of the Congress, provided of course that there is good ground for the execution of such measures. It may, indeed, be impossible to protect mankind from tuberculous infection through individuals in the same way as is done in the case of contagious disease generally; but if it be true that much of human tuberculosis is derived from the lower animals, it is at least comparatively easy to close this avenue of contamination. Not long ago it was maintained that bovine and avian tuberculosis were diseases of a nature distinct from human tuberculosis. Even since Koch's discovery this contention has been upheld, based now not merely upon gross anatomical differences, but on the infi-

nitely more minute differences in the morphology of the bacilli that are met with in various kinds of animals. However, this view has now been practically abandoned; and, in his recent report to the Agricultural Department, Professor Crookshank dealt it the coup de grace. It appears incontestable that the morbid condition known as tuberculosis is of the same kind in man as in those animals which are specially prone to it, some of which, such as cattle and poultry, form in many ways staple articles of human food. It has been abundantly proved that any portion of tubercular products administered to animals (prone to tubercle) in food or by inoculation will reproduce the disease in the latter, so that it would, with our present knowledge, be an act amounting to a crime to give an infant milk from a cow suffering from tubercular mammitis. Yet who knows how much this has been done in the past, or how much of infantile mortality from *tubercles mésentériques* may be attributable to the direct introduction into the alimentary canal of the parasite—*readi* which would have its analogy in the ingestion of an attack of typhoid fever from the ingestion of water contaminated with the typhoid virus, or of trichinosis from the ingestion of a piece of raw, measly pork.

The Paris Congress of 1889, of which the Transactions have just appeared, advanced this question a stage farther, supporting it by many and forcible arguments, as may be judged by the following resolutions passed at the meeting: "It is imperative that every possible means should be adopted, comprising compensation to parties interested, for the general application of the principle of seizure and general destruction in totality of all flesh belonging to tuberculous animals, no matter how slight the specific lesions found in such animals" (Page 100). And again: "The Congress expresses the wish that tubercular be included in the sanitary laws of all countries in the world, among contagious diseases requiring special prophylactic measures" (p. 716), while the French Government, at the very time of the session of the Congress, promulgated a decree enjoining the destruction of carcasses in which the tubercular lesions were limited to parts of the body. This is the question which recently excited so much interest in Glasgow, where a judicial inquiry, lasting many days, was made for the purpose of ascertaining the order of the local authority for the destruction of two animals condemned as unfit for human food on account of the presence in them of such limited evidence of tubercular disease. The questions of scientific investigation were submitted to the close analysis of legal advocates, and expert witnesses were called to give evidence

on both sides. The views of the Paris Congress prevailed, and Koch's bacillary theory, with all its consequences, has received judicial sanction at the hands of Sheriff Berry, who upheld the local authority, and declared that the flesh (in itself having the appearance of health) of a tuberculous animal is unfit for human consumption. The inquiry was one of great interest and importance, and the evidence given deserves to be widely studied.

It is needless to point out the influence that this decision may have, since tubercular disease in one form or another is perhaps the commonest affection from which cattle suffer; and the general application of the principle therein laid down may necessitate a considerable change in arrangements connected with food supply as well as in sanitation generally.—*London Lancet*.

**SOME POINTS IN THE DIAGNOSIS OF PYO-SALPINX.**—A paper read by Dr. R. B. Hall, of Cincinnati, before the American Association of Obstetricians and Gynecologists at the meeting at Cincinnati, September 17, 1889:

The author believes the importance played in the production of suffering by this disease has not received the attention which it merits. The general practitioner sees and treats the great majority of these cases before they are seen by the operator, and, if it is hoped or expected to afford relief to a great number of suffering women all over the land, the subject of diagnosis must be better understood than at present. The importance of septic infection in the production of inflammatory disease of the uterine appendages is the cause of these diseases in a very large percentage of cases. Repeated attacks of acute exacerbations, from perhaps trivial causes, finally produce complete closure of the ends of the tubes. As a consequence, the normal secretions of the tubes soon become pathological, and by repeated attacks of inflammation may become changed into pus, producing the typical pyo-salpinx. The speaker is convinced that this affection frequently follows puerperal diseases and gonorrheal infection, but does not consider these the most common causes of the disease. He believes pyo-salpinx to be contracted in two different ways: (a) By a chronic process, causing dropsy of the tube, which by repeated attacks of inflammation is changed to pus. (b) It may be rapidly produced by an acute process following gonorrhea and puerperal diseases—a history of almost constant suffering for years directed to a certain locality, perhaps

originating in an attack of pelvic or abdominal inflammation, connected or not with parturition. To this may be added sterility, and we have a most important aid to a correct diagnosis in the history of the case. Diseased appendages can usually be recognized by a vaginal examination, yet this is not always possible. In most cases it is difficult and in many impossible to make out the exact disease of the appendages except in cases of pyo-salpinx. We usually have an irregular ovoid tumor, showing swelling and contractions not found in any other pelvic tumor but tubal collections. This tumor is generally of small size; it may be in the retro-uterine space extending toward the pelvic brim on the one side, with a second tumor on the other side higher up, or it may be distinctly felt as a narrow furrow, which is occasioned by a portion of the uterine end of the tube remaining undistended by pus, while the distal end of the tube is enlarged to form the tumor. This furrow is not so plainly felt in those cases where there is a periodical discharge of the pus through the tube into the uterine cavity. This is a very valuable sign to help in making a diagnosis. If we have all the other symptoms of pyo-salpinx with a history to confirm them, where we can feel the enlarged tube before a discharge of pus from the uterus, and immediately after the discharge has occurred we find that the tube has collapsed, then we have proof positive of the existence of pyo-salpinx.

If the previous history of the case be carefully learned and given due weight and consideration, the author believes the diagnosis is not so difficult as is usually thought. The uterus is more or less fixed and misplaced. In the majority of cases seen by him there has been pain during defecation, particularly where the tumor occupied the retro-uterine space. Most cases gave a history of dyspareunia. If pain has long been a prominent symptom, and it is evident the tube contains pus, the case must be looked upon as serious and demanding prompt relief. Delays are dangerous, as the bursting of the tube may cause fatal peritonitis, and escape should be afforded the offending pus by removal of the tube.

**CIRRHOSIS OF THE LIVER.**—*Cirrhosis of the Liver Causing Hemorrhage into the Pelvis.* At the Hunterian Society (March 28, 1889) Dr. Pitt showed a specimen of extensive hemorrhage into the pelvis associated with cirrhosis of the liver. Small hemorrhages are common, but extensive hemorrhages are rare.

The blood was effused freely into the left broad ligament, slightly into the right, and formed a large tumor over four pounds in weight surrounding the bladder by a blood clot one inch and a half thick compressing it and causing retention of urine, probably from pressure on the ureters for the last twenty-four hours of life. The blood extended into the submucous tissue of the bladder, it also spread through the inguinal canal up on to the abdomen, chiefly on the left side, as far as the ribs and nipple, forming a layer one inch thick and three inches wide. The liver was a typical hobnail cirrhosis. The kidneys were healthy, except for some scarring. The specimen was taken from a woman aged thirty-eight, admitted with edema, pyrexia, and cough, who became increasingly drowsy and died.

**Non-alcoholic Cirrhosis.** Dr. Goodhart, at a meeting of the Pathological Society of London (April 16, 1889), described a case of cirrhosis of the liver occurring in a female aged twenty-one. There was absolutely no history of alcoholism or syphilis. Two years before her death she had married, and three months later had a miscarriage which was followed by septic poisoning. Later she developed jaundice and ascites, and vomited large quantities of blood. The *post mortem* examination revealed an ordinary case of cirrhosis with enlarged spleen. He suggested that the cause was plugging of the portal vein from the septic process with secondary shrinking of the liver and fibrotic change. In the ensuing discussion Dr. Moore related in detail a case of hematemesis which was associated with the presence of a firm cord-like clot in the portal vein; the liver was firm but not cirrhotic. Dr. Crooke referred to the effects of specific febrile disease on the livers of young children; he had many times met with interstitial hepatitis after scarlet fever, and this might lead to a contraction like that which occurred in the kidney. The president (Dr. W. H. Dickinson) had known severe cases of cirrhosis fatal under two years of age, and many such cases had followed measles and scarlet fever.

**The Curability of Interstitial Hepatitis.** Professor Semmola, of Naples, protests against the exaggerated importance attached to the anatomical basis of disease. The error is common of associating the *post-mortem* changes of the last and probably incurable stage with the symptoms of an earlier and possibly curable stage. He regards the atrophic stage as seen in the dead-house as the dress of the disease, and as far as therapeutics goes he refers merely to the early condition when the liver is large and the new tissue has not become hard, contracted, and fibrous. Semmola has long ago (1869) suggested the possibility of the curabil-

ity of interstitial hepatitis. And at the International Medical Congress at Amsterdam, in 1879, he brought forward a series of cases in support of his views. Millard *Ferraz Moland* has advocated the same proposition, and has since published a series of cases in which a cure has taken place.

Semmola, in his recent cases, does not appear to have drawn a line between those due to malaria and those of alcoholic and syphilitic origin. It is possible that the former may be more readily curable than the latter. It would also appear that sufficient account is now given to the establishment of a collateral circulation to the consequent disappearance of ascites and other symptoms, the interstitial hepatitis remaining unaltered. The principle of Semmola's treatment is the rigid restriction to a milk diet. More solid dietary, and especially meat, increases the hepatic irritation and exaggerates the disease. — *Medical Medical Journal*.

**TREATMENT OF ABSCESS OF THE LIVER.** (By M. Chauvel.) I have had opportunity to observe four cases of Abscess of the Liver in military hospitals. These abscesses occurred in soldiers returning from Tonquin and Africa, all of whom were evidently exposed to the result of dysentery. The air of their native country had at first complicated their condition, but soon the attacks of dysentery and diarrhea recurred, with febrile exacerbations, quotidian fever, intercostal pains, either vague or localized to the hepatic region, pain about the scapula, and absolute anorexia. Abscess of the liver was diagnosed, the diagnosis being verified by means of an exploratory puncture. The development of these various symptoms was much more sudden in the cases of the soldiers from Tonquin than in the single instance of the one from Africa.

In two of the cases the abscess occupied the right lobe, in the other two the left lobe; these latter cases terminated fatally.

Incision with the bistoury presented no serious difficulties; it corresponded with the seat of swelling, at which point the puncture had been made with the trocar.

The following are the conclusions derived from a study of these four cases:

1. Immediate, direct incision of abscess of the liver by means of the bistoury presents no danger as regards the development of peritonitis, if it be made antiseptically.

2. The opening should be large and lead directly into the abscess cavity. On account of the retraction of the liver after the evacuation of the fluid, it is well to make it as high up as possible; if it retract upon the collapse of the ribs, resection of the latter may be indicated.

3. It is useless and perhaps dangerous to suture the liver to the edges of the parietal wound.

4. The large opening should be made early, and the exploratory punctures are clearly indicated as soon as there is a suspicion of pus.

5. It is almost always impossible to recognize the existence of multiple foci with sufficient accuracy to reject the possible intervention of an accessible tumor. In these perplexing cases the large incision in the principal focus causes the disappearance of one of the sources of fever; it favors the opening of the secondary foci into the principal cavity, already emptied; and if it does not arrest the progress of the affection, at least it exerts no unfavorable influence upon its course.

6. Abscesses of the left lobe appear to be the more serious—a fact which may, perhaps, be explained by the possibility of a pericarditis by extension, and by the probability of other collections of pus in the right large lobe.—*Journal American Medical Association*.

PHYSIOLOGICAL ALBUMINURIA.—Dr. Hans Malfatti, of the Laboratory for Applied Medical Chemistry at Innsbruck, controverts the belief that albumen or serum albumen is one of the normal constituents of urine in healthy subjects. He mentions the case of a healthy man in whom the ordinary tests apparently proved the presence of albumen, while Heller's test gave negative results. There was also a singular want of correspondence between the various reactions, as either the test by boiling seemed very satisfactory, and acetic acid and ferrocyanide of potassium gave no reaction, or *vice versa*. Filtration after the test by boiling did not always remove the apparent albumen, which was still discoverable in the filtered urine by ferrocyanide of potassium, especially when chloride or acetate of sodium had been added before boiling. The addition of ferrocyanide of potassium after boiling and adding acetic acid increased the turbidity considerably. When the urine mixed with acetic acid had been allowed to stand, and was then filtered, acetic acid and ferrocyanide of potassium did not make it so turbid, and had sometimes no effect at all when the same filter was used repeatedly, especially with the addition of acid phosphate of soda, which sometimes prevented the occurrence of turbidity even after a single filtration. After the urine had been treated by reagents which throw down mucin, but not albumen, no albumen could be found, though many tests were tried. The author concludes, from his experiments, that in the case reported by him albumen was either entirely absent or present in an extremely small quantity only (1 in from 2

to 4 million parts). He considers that the body which has given rise to the supposition that albumen occurs in physiological urine is not an albumen, but a kind of mucin, which is easily broken up into typical mucin and a peptone-like body, and he believes that the presence of albumen in the urine of apparently healthy persons is really indicative of a morbid process, though not necessarily of one at all of a serious character.—*London Lancet*.

INFECTIOUS JAUNDICE.—Several cases have been observed in Montreal within the last few months. The patients were children, and the prominent symptoms were jaundice and fever. Infection was probable, as some of the children in the neighborhood were similarly attacked. The whole subject is attracting considerable interest in Europe, and many clinical observers are paying attention to it. Fränkel, in the course of an article "On the Study of the So-called Weil's Disease," relates the history of a case in which symptoms resembling decidedly those of Weil's disease came on as the result of an external wound which had taken on a slightly erysipelatous action. The symptoms soon declined, and the patient became free from fever and felt almost well, except that he suffered from great lassitude. After some eleven days he experienced a slight relapse with moderate elevation of temperature and an increase in the enlargement of the liver and of the spleen. This observation induced Fränkel to make a careful critical examination of the numerous publications on the subject of Weil's disease, and he came to the conclusion that "the collection of symptoms described by Weil have no specially characteristic significance either in their etiology, symptomatology, or in their anatomical relations. Evidently in the cases described it appears to act as a septic infection in which the poison enters the body from without or from the intestine. The febrile jaundice, the extensive implication of the nervous system, the enlargements of the liver and of the spleen, the albuminuria, are no more characteristic of a special disease than the relapsing type of the fever. Fränkel therefore proposes to abolish the name Weil's disease, and to substitute for it that of infectious or septic jaundice.

"The following reasons for regarding this affection as an independent one have been advanced. From acute yellow atrophy of the liver it is distinguished by the swelling of that viscus, by the high temperature, by the simultaneous swelling of the spleen, by the involvement of the kidneys, and by the absence of hemorrhage; and from catarrhal jaundice by the higher range of temperature and the implication of the spleen, liver, and kidneys. It

resembles relapsing fever in many respects, especially the variety called by Griesinger bilious typhoid. This disease, however, never exists in sporadic form, and hence may be excluded even in the absence of the important negative evidence that would have been furnished by an examination of the blood for the spirillum of Obermeier. The concurrence of jaundice, apyretic intervals, and distinct relapses suffices to exclude the view that the affection is an abortive typhoid complicated with jaundice. Among the widely-varying symptoms and *post-mortem* appearances of the numerous cases of 'Weil's disease' now on record there is nothing distinctive of a hitherto unrecognized disease. On the other hand there is strong evidence that some of them were cases of septic poisoning. In Fränkel's case, which corresponded in all respects with those described by Weil, the point of septic infection was a wound of the head; and in Fedler's cases, at least in the nine butchers, the infection may have entered the system in a similar manner, through cuts and abrasions too slight to attract attention, or through the ingestion of decaying meat."—*Montreal Medical Journal*.

**SURGICAL TREATMENT OF ABSCESS OF THE LIVER.**—L. Defontaine (*Gaz. des Hôpitaux*, No. 58). Complicated abscesses of the liver generally can not be operated upon; simple abscesses can usually be treated successfully by an operation if recognized early. The latter is found idiopathically or secondarily after dysentery and other ulcerations of the bowels; in cases of gall-stones causing inflammation around the small stones in the gall-ducts, or after the rupture of a gall-duct obstructed by a stone, and in cases of pyemia, which latter usually produce many small abscesses. The large abscesses of the liver are usually situated in the right lobe.

The diagnosis is to be based on the following points: pains in the right hypochondriac region, radiating to the right shoulder; remittent fever, and occasionally jaundice; general debility, and loss of flesh.

D. recommends the following method of treatment: When the abscess can be reached from the abdomen below the last rib, it is to be located by exploratory puncture and a little pus removed. Then an incision is made of eight to ten cm., if possible, in the direction of the greatest diameter of the tumor, or parallel to the edge of the ribs, cutting through to the peritoneum. Arrest hemorrhage while cutting through the peritoneum. The pus is to be removed by aspiration, and the liver is then to be secured to the parietal peritoneum; and finally a broad incision of the abscess is made,

drainage tubes placed, and the wound antiseptically dressed.

When the abscess can not be reached from below, the operation is to be performed within the chest, after resection of one or more ribs. After opening the parietal and diaphragmatic pleura, Thornton advises to first suture both folds and then incise the abscess through the diaphragm. The after treatment is the same as in the previously mentioned method. Recovery takes place usually in from four to six weeks.—*Brooklyn Medical Journal*.

**HEART COMPLICATION IN GONORRHEA.**—Gluzinski, in a recent number of the *Pracod Lekarski*, gives some details with respect to circulatory diseases depending on gonorrhea. Complications connected with the serous membranes of the internal organs, such as that of the heart, were unknown until recently. Brande (1854) published two cases of endocarditis and pericarditis respectively in connection with gonorrheal rheumatism. Simund (1858) observed two cases of pericarditis in which Gluzinski has collected thirty-one cases. The following conclusions might be derived from these observations: (1) Pericarditis as well as endocarditis might supervene in the course of gonorrhea. (2) These may develop after gonorrheal rheumatism, but also without the presence of such an affection. (3) The complaint often assumes the character of a severe infectious disease, as in endocarditis ulcerosa, runs an acute course, and sometimes gives rise to failure of the heart. The fact, that of the thirty-two cases published in only two were the patients women, might be explained by the suggestion that in the case of acute rheumatism in the female sex the presence of a simultaneous gonorrhea was less frequently inquired for. Gluzinski argues that it must not be supposed that these complications were analogous to orchitis or cystitis set up by extension of the inflammatory process *per continuitatem* or *per contiguitatem*. He gives the following explanation: The synovia of joints affected with gonorrheal rheumatism has been repeatedly examined for microorganisms. Sordé, who believes they have discovered a specific microbe, consider the rheumatism to be a direct result of the gonorrhea. Others who have failed to find gonococci or other pyogenic microorganisms in the synovial fluid regard this affection as a secondary one, due to the penetration of pyogenic micro-organisms owing to a lesion in the urethral mucous membrane. This hypothesis was confirmed by a case published by Weichelbaum where gonorrhea was complicated with endocarditis and cardiac failure, and the streptococcus pyogenes was proved to be pres-

ent in the vegetations on the valves. Dr. Gluzinski said that complications did not always occur in so acute a form as the endocarditis ulcerosa or pericarditis acuta. In eight cases which he had observed these complications were of a mild character. The patients complained of "stitch" in the left chest and palpitations of the heart. There was accelerated and increased action of the heart, and frequently also a slight pericardial *râle*. In spite of the most careful examination no other affection could be detected but gonorrhea. These cases mostly ran a rapid and mild course and might very easily be overlooked. They deserved the greatest attention, however, as endocardial murmurs and cardiac failure came on in two of these cases. In the majority rheumatism was either quite missed or came on after the cardiac affection had set in. In all the patients there was gonorrhea of long standing. Gluzinski concluded that, just as acute affections of the heart occurred in acute gonorrhea, mild diseases of the serous membrane of the heart could also supervene in the course of chronic gonorrhea.—*Montreal Med. Journal*.

**LARGE BURNS.**—On February 25th C. W., aged three years and six months, being left alone in the kitchen, played with the fire, burning himself in a dreadful manner. I saw him half an hour after the accident, and found him in a state of collapse, suffering from shock. The extent of the burns, subsequently ascertained, was as follows:

All over the abdomen, width five inches, length seven; down the left thigh, width three inches, length four; on the back, nine inches long and four wide; round each arm, three inches long and four wide; round the neck, three inches long and three wide. The true skin was burnt through over the whole of the abdomen and a portion of the back. Linen rags steeped in linseed oil and lime-water were applied to the burnt surfaces. Purgatives, at first administered, were discontinued, as peritonitis set in, accompanied for nearly a whole day with suppression of urine. The child lay on its back with its legs drawn up, the bowels not being relieved for eight days. There was delirium at night for the first five or six days. The treatment was as follows: Brandy during collapse, with bark and ammonia; bromide of potash for rest at night. Linseed oil and lime-water were continued for about a week, at the end of which linseed poultices, with plenty of linseed oil in them, were applied to the abdomen and part of the back to remove the eschars. When the wounds were perfectly clean the whole of the raw surfaces were smeared with an ointment composed of lard, zinc, and glycerine, under which they slowly

but surely healed. The child's strength was kept up by tonics. There is a very slight contraction in the left groin, where the thigh and abdomen wounds meet; in all other respects the child is now convalescent.—*Dr. T. S. Smith, London Lancet*.

**ANTIPYRIN IN RENAL DISEASE AND DIA-  
BETES.**—In the summer of 1888, while acting as honorary medical officer to the Cottage Hospital, Clevedon, Somerset, the following case came under my care:

On the card over the patient's bed was written, "J. B., aged twenty-nine, Bright's disease." The matron informed me that the case was regarded as hopeless. The patient was admitted March 3, 1888, having been in good health till two months before. She was then seized with a diphtheritic sore throat, and soon after ordered to Clevedon for change of air. On the journey she caught cold, and dropsy quickly supervened. From the date of admission to the following June, in spite of careful nursing and medical treatment, the malady made steady progress.

I saw her for the first time on June 14th. There was then extreme general dropsy, the abdomen, face, and extremities being tensely distended with dropsical effusion; great pain in the back, especially the lumbar region; intense headache, failing vision, heart action weak and irregular, difficulty of breathing, owing probably to a pushed-up diaphragm and pleural effusion; the skin sallow, tense, and shining; urine scanty, of high specific gravity, and loaded with albumen; anemia and general prostration. The condition of the eyes was very characteristic, the lower lids forming two distended translucent pouches; but the condition of the ocular conjunctivæ was very striking. These were, to a large extent, raised from the sclerotic in transparent bladders of effusion, producing chemosis, and seriously endangering the circulation of the cornea.

From previous slight but inconclusive observations of antipyrin in renal cases, and with a view to relieving the intense headache, I ordered three grains twice a day, with strict instructions that the action of the heart should be carefully watched. The need for this precaution was quickly demonstrated by the increased irregularity, fainting, etc.

On the third day the dose was reduced to three grains daily. From this date general amelioration of symptoms was observed, and constant steady improvement recorded. After a few days a tonic supplemented this treatment, and in the course of three weeks

a great change was observable. The dropsy was much less, the intense headache relieved, the appetite improved, and the patient much brighter and more hopeful. By the beginning of August she was up and about visiting friends. All traces of dropsy had disappeared, the general health was good, and there remained only a small quantity of albumen in the urine. On August 13th she was discharged for a convalescent home.

With regard to the effect of antipyrin in diabetes, I may be allowed to cite the following case, though incomplete:

While spending some of the winter months at Arcachon, a clergyman, aged sixty-four, consulted me. He had been in failing health for some time, and his French physician was treating him for diabetes. I found a large quantity of sugar in the urine. I again adopted the antipyrin treatment, and the same cardiac intolerance was manifested. I reduced the dose to three grains daily. At the end of three weeks his health was much improved, and the amount of sugar reduced to one fourth. I afterward lost sight of the case.—*Dr. M. H. Feeny, British Medical Journal.*

NOTES OF A CASE OF TRICHINOSIS.—On March 12, 1889, I was asked by one of my assistants, Dr. McAleer, to see a woman, aged thirty, suffering for about ten days from what he thought must be acute spinal meningitis. We discussed the case as we went along, and I suggested it was possibly a rare form of enteric fever, spinal meningitis being so uncommon. After examining the patient, however, we came to the conclusion it was a case of trichinosis, and, through Dr. McAleer's help, I was enabled to obtain the following notes:

M. A. B., aged thirty, married thirteen years; has had six children, five of whom are now living; family history good; no previous illness. She was particularly fond of raw meat, and, when cooking any, was accustomed to eat small portions of the lean. On February 23d she bought some home-cured ham, eating, as usual, some of it raw. On February 27th, a very cold, snowy day, she went to Barnsley, where she had a severe attack of shivering and vomiting. On reaching home she sat in her wet clothes for some time, and on going to bed she had great difficulty in pulling off her boots on account of the swelling of her feet. Her face, hands, and legs were also swollen, and her eyes twitched.

On February 28th she could hardly open

her eyes on account of the stiffness of the lids; her eyes were bloodshot and painful; there was intolerance of light, great pain in all her muscles, cold sweats and shivering, choking sensations, vomiting, and diarrhea. She continued in this condition until March 2d, when she consulted Dr. McAleer, complaining chiefly of severe pain in the bowels. She was ordered to bed and attended at her own home.

March 4th: Pain in legs, which she was unable to move, very severe, could not grasp with her hands; pain and swelling round wrists; swelling of abdomen; headache; delirium; no albumen in urine.

March 6th: Swelling in legs, arms, and eyelids increased. Profuse perspiration; temperature 103°, pulse 120; general muscular pains, sardonic grin, difficulty of speaking and of swallowing, but no stiffness of jaws; thirst, loss of appetite, no power over legs, dyspnea, tongue coated.

March 8th: Temperature 103.2°, pulse 125; muscular pains increased, and most severe in calves of legs; could not sit up in bed; dyspnea increased; no albumen in urine.

March 12th was the day I first saw her, and she was then commencing to get better. I found her lying on her back in bed with the thighs slightly bent on the abdomen, and the legs on the thighs. She looked very ill and worried, and had a most peculiar retraction of the corners of her mouth, very similar to a commencing *trismus sardonicus*. Temperature 120°, pulse 115; profuse perspirations; heart-sounds and respiratory sounds normal; the abdomen was not tympanitic; there was pain on pressure on the right iliac fossa but no gurgling, but the same pain on pressure was present equally all over the abdomen and all over the body generally, more so on the thighs and much more so in the calves; there was no diarrhea; there was no special tenderness beyond the general tenderness everywhere over any region of the spine. There was no loss of sensibility anywhere; both legs appeared paralyzed from the knees downward, but this paralysis was only apparent, being caused by the agonizing pain occasioned by the slightest movement. Both calves were swollen and hard to the touch. The knee-jerk was exaggerated, and ankle-clonus was present in the right leg, which was the worse of the two. The pupils were slightly dilated, but answered to light, and both optic disks were perfectly normal. There had been no retention nor incontinence of feces or urine. There had been

edema of face, arms, and legs, but there had been no albumen in the urine, some of which I examined and found healthy.

She gradually improved, and on March 20th her temperature was normal. Swelling and pain in arms and legs almost gone, but the legs were still weak; no perspiration. She got quite well in about five weeks' time. I saw her a few days ago, when she said she was quite well, but that still she sometimes had slight stiffness and pains in her legs. Practically the duration of the illness was twenty-one days—from February 27th to March 20th. Bristowe says the diseases most likely to be confounded with trichinosis are (1) acute tuberculosis, (2) acute rheumatism, (3) enteric fever. The termination of this case excludes the first. The muscular pains, not joint pains, are against the second, to which, in fact, beyond the perspirations, it had no resemblance. The sudden onset, the general edema, and the short course are all against the third.

A disease much more difficult to distinguish from trichinosis is acute idiopathic spinal meningitis, but the absence of sphincter troubles—in fact, of any paralysis, the exaggerated knee-jerk and ankle-clonus, the edema, the age and sex of the patient, and the rapid recovery—are strongly against this disease. The vomiting and diarrhea, coming on four days after eating raw ham, accompanied by severe fever, the edema of eyelids, face, arms, wrists, etc., without any albumen in the urine, and the severe muscular pains all over the body without any loss of motion or sensation, seem to me to point clearly to this being a real case of trichinosis, ending favorably probably from the small amount of the raw meat that was consumed.

I made inquiries at the shop where the "home-fed" ham was bought, and found that it was American, and that all was sold on the same day. No attempt has yet been made to harpoon any of the diseased muscle, but I intend doing so, and I shall be glad of any hint as to the best mode of procedure.—*Dr. W. M. Jones, British Medical Journal.*

**MIXED INFECTION IN GONORRHEA.**—Analogous to the definite sequelæ which are observed in various affections, and which, as proved by bacteriological investigation, are caused by the entrance of various micro-organisms into the tissues at the same time, are the various complications of gonorrhea, such as inflammation of the erectile tissues, peri-urethral abscess, bubo prostaticitis, vesical catarrh, gonorrheal rheumatism, peri- and para-metritis, inflamma-

tion of the fallopian tubes, Bartholinitis and endocarditis. These are mixed infections produced by the gonococcus, together with other pathogenic micro-organisms. The author adduces in substantiation of this statement the assertion of Bumm that the gonococci develop only in cylindrical epithelium, or in tissues which in their histological structure are closely related to cylindrical epithelium, and the fact, as experimentally demonstrated by Rinecker, that when gonococci are injected into the connective tissues they disappear without leaving a trace behind them. Throughout the entire course of gonorrhea, however, opportunity is afforded for the entrance of other pathogenic organisms through the ulcerations of the mucous membrane. These find, in the profuse secretion present, the very best conditions for their propagation and further advance into the lymph and blood channels, whereby the complications of gonorrhea arise. Were it not that gonorrhea is a purely local affection of a mucous membrane provided with cylindrical epithelium, these complications would be observed very much oftener. The relative frequency of these complications, however, is explained by the readiness with which micro-organisms other than those of the gonorrheal variety find their way from the diseased mucous membrane of the genitalia into the tissues and lymph channels.

Bumm has discovered a yellowish-white diplococcus which, as well as the staphylococcus aureus and albus (which are often found in gonorrheal complications, together with the gonococcus), may easily be confused with the gonococcus, and thus mislead one into the belief that the pathological process is a uniform one; whereas, in point of fact, it is a question of mixed infection.—*Gerheim, Centralblatt für Gynäkologie.*

**THE RADICAL TREATMENT OF VARICOSE VEINS.**—The following case will be of interest on the above subject: D. J., a laborer, aged twenty-one, consulted me on February 4th in consequence of the great distress and annoyance he was suffering from a varicose condition of the veins of both legs, but principally the left. On examination I found the left saphena greatly distended and very tortuous, and appearing like a bunch of purple grapes in the popliteal region; the right was not so bad, although distinctly varicose. I immediately recommended an operation for the total occlusion of the vein in preference to the palliative treatment by elastic stockings or rubber bandages. After the patient had consulted with his friends he determined

to run the risks of the operation (if any) and allow me to operate. On February 8th I inserted a number of barehip pins along the course of the vein, each pin dipping well down under the vein, and placed about an inch from its fellow. I then compressed the vein by a figure-of-eight ligature over a small piece of bougie lying over and perpendicular to it. I completed the operation by injecting into the vein where most distended four drops of the liquor ferri perchlor., as recommended by Erichsen, and kept the limb suspended for a few days. There was severe pain for the first twenty-four hours, for which I prescribed morph. mur.  $\frac{1}{4}$  gr. every two hours. This had the desired effect. There was little or no constitutional disturbance, and the pain was entirely gone by the third day. I removed the pins ten days afterward. There was slight suppuration along the track of the pins, which continued for a few days. Other than this there were no bad symptoms. I applied a dressing and a bandage to the limb, and allowed the patient up on the thirteenth day. He resumed work three weeks after the day on which I inserted the pins.

On March 14th he came and showed himself, and what was once a large distended vein is transformed into a tough and fibrous cord. The patient informs me that he has neither pain nor ache along the track, and suffers no distress whatever in his work. Of course such a happy state of things may not continue, but such a good result so far speaks well for the radical treatment of varicose veins.—*Dr. R. D. Patterson, British Medical Journal.*

**THE TREATMENT OF HYDATID DISEASE OF THE LIVER.**—*Dr. Davies Thomas*, whose contributions to the study of hydatid disease have been numerous and important, sums up the results of his researches (*Australian Medical Journal*, June 15th) as follows: That there is reason to believe that tapping operations fail to cure the patient in fully forty per cent (or more) of the cases in which they have been tried; and that, taking aspiratory puncture and ordinary tapping operations together, the deaths amounted to nearly eighteen per cent, but the mortality following aspiratory puncture was only about half that of punctures with an ordinary fine trocar. Speaking generally, the greater the number of punctures required in a given case the smaller is the probability of cure by tapping alone. Simple puncture, though generally devoid of risk, has been known to cause sudden death, sometimes from

shock, sometimes, in the case of pulmonary hydatids, from suffocation by the fluid contents of the bladder worm. As to puncturable affections and the use of electrolysis, there is no evidence in their favor that does not apply to simple puncture, while each has drawbacks of its own. The mortality of the various forms of radical operation is given as follows:

Cauterization, 33.68 per cent.; double incision, 26.66 per cent.; Simon's method, 18.0 per cent.; Mikulicz's method, 12.05 per cent.; Landmann's method (abdominal method), 10.00 per cent., and disseminated incisions, 2.41 per cent. From which it appears that abdominal section yields an even lower mortality than puncture of the cyst.—*London Lancet.*

**CASE OF POISONING BY HYOSCYAMUS.**—Instances of poisoning by this drug being apparently rare, the following notes may be somewhat of interest:

Mrs. S., aged about fifty, had been in the habit of occasionally taking tincture of hyoscyamus for gastralgia. On September 30th I was suddenly summoned at 3.30 p. m. to attend her, she having swallowed by mistake, about five minutes previously six drams of tincture of hyoscyamus. (B.P.) In the mean time she had taken some mustard and water. I found her much excited; pulse rapid, 130, regular; pupils equal and reacting to light and accommodation. Free nausea was immediately produced by ipecac. sulph. and vinum ipecac., followed by copious draughts of warm water. In from twenty to twenty-five minutes after taking the poison the pupils began to dilate, pulse 120, and there was now great weakness and trembling of limbs, marked dryness of throat, and flushing of face. She walked with assistance to the bed, though with difficulty, and her extremities were cold. In a short time her pupils were fully dilated, and no longer reacting to accommodation or light; no headache. At 4.00 p. m., although sensible and answering questions rationally, she had difficulty in speaking, and seemed confused, but not giddy. At 5.30 p. m., she tried to rise from the bed, but found herself powerless to move her legs; both upper extremities were also almost completely paralyzed, and her power of grasping was feeble. She was now slightly delirious, wandering in thought and manner. At 8.30 p. m. pupils still dilated; pulse 84, irregular, she was still delirious, but if spoken to sharply answered questions rationally. Later on she was reported to be progressing favorably. On visiting patient the following morning I found her much

better, having slept three hours. Vomiting had occurred during the night, which she attributed to pain in the stomach, probably due to the mustard. The bowels had been well relieved by an aperient administered the previous night; tongue clean; pupils smaller, but still rather dilated; pulse regular, 84; dryness of throat had disappeared; she could walk, though there still remained great weakness of limbs; was now able to grasp firmly, and her speech was once more normal. The following day she had recovered completely.

The respiration was unaffected throughout. A slight deafness with which she was troubled was much aggravated while under the influence of the drug.—*Dr. Arthur H. Dodd, British Medical Journal.*

**NODULAR PERIOSTITIS IN CHILDREN'S RHEUMATISM AND HEART DISEASE.**—Of the occurrence of subcutaneous nodules we have records enough and to spare. It is not so generally known that nodules are rheumatic manifestations in other tissues. Nodular pericarditis, pericarditis with fibrous nodules, nodular pleurisy and nodular periostitis are, however, undoubted facts. I have notes of a few cases in which subcutaneous nodules were associated with nodules growing from the bone—exostoses—resembling subcutaneous nodules in every respect, except that they are firmly fixed to the bone and can not be dislodged. One case, a boy aged ten, died, and then I was able to prove *post-mortem* that his olecranon had nodular exostoses growing therefrom. He had many nodules in the valves of the heart, chiefly the mitral valve. Rheumatism is a frequent producer of fibrous nodules, limited localized lumps of connective tissue; a nodular sclerosis, different from the nodules of tuberculosis and from the limited fibroid formations of syphilis, but nodules or limited fibrous formations all the same.—*Dr. A. Money, London Lancet.*

**ON CREOLINE IN DYSENTERY.**—N. P. Sossowsky (*Vratch*, No. 14, 1889) used in sixteen cases of dysentery clysters of a solution of one half per cent of creoline. The clyster (2 to 3 and even 3½ liters) was generally given twice a day, sometimes three and even four times. No disagreeable secondary symptoms. The patients did not complain of either smarting or abdominal pain. The results obtained were as follows: In two cases the disease was broken up after two injections; in nine cases the bloody stools disappeared on the third day, in two on the fifth, in one on the sixth, and in another on the ninth. In the last case the appearance of putrid matter in the stools was

not checked, but the patient recovered nevertheless. Not one of these patients died, although there were a great many cases with fatal termination reported in the city. From these observations the author draws the following conclusions:

1. Clysters of a half-per-cent solution of creoline possess antiseptic qualities and seem to be less dangerous and toxic than the clysters of sublimate or phenol.

2. Clysters of creoline check the blood without irritating the intestinal channels.

3. Cases acute from the beginning, with frequent tenesmus and copious bloody stools, take a more favorable course and are cured more rapidly than cases insidious at the beginning, characterized by catarrhal stools.

4. In cases where the creoline clysters do not stop the development of the intestinal catarrh, clysters of tepid water, and subsequently of a solution of acetate of lead one-half per cent, or of tannin of 1–2 per cent, should be prescribed; at the same time a decoction of the bark of quinquina should be taken internally with sulphate of soda.

The author has successfully used the same treatment in two children, one eleven and the other nine months old. Dr. Kolokoloff has prescribed creoline clysters (1 per cent) in twelve cases of dysentery; all the patients recovered without showing at any time alarming secondary symptoms.—*American Medical Association Jour.*

**INSTANTANEOUS CURE OF WHOOPING-COUGH.** In the Archives of Pharmacy, 1889, page 382, it is stated that the instantaneous cure of whooping cough was attained by Dr. M. Mohn, as a result of accidentally observing that the disinfection of the sick-room of the whooping-cough patient by sulphurous acid caused the disappearance of the paroxysms with a rapidity bordering on the marvelous. The patients are freshly clad in the morning, and placed in another room, in which they remain during the day. Meanwhile, 25 grams of sulphur is burned in the sick-room to each centimeter of space; and after bed-clothing, garments, etc., have been properly spread out, and the sulphurous acid been permitted to permeate the air for five hours, the patients return to their disinfected sleeping-rooms in the evening, and are cured of whooping-cough.

Physicians may not generally be aware of the fact that sulphur bricks are obtainable, which may be burned to secure the effects of sulphurous acid by inhalation or for general disinfectant purposes. Parke, Davis & Co. supply these, as well as a general line of disinfectants for household use, and afford physicians all information concerning them on request.

# The American Practitioner and News

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D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } - - - Editors.

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## A DANGEROUS EXPERIMENTER.

The *naïveté* of some therapists who combine in prescriptions the new synthetic drugs with one another and with other chemicals, without thought of their compatibility or incompatibility, has ceased to be interesting.

Thus we too often hear of Dr. A. or B. combining antipyrine with quinine or salol, or antifebrine with phenacetine, or some acid, base, or salt. If the druggist discover incompatibility, he would of course stand between the doctor and the patient; but it is hardly needful to suggest that changes might take place in these mixtures slowly after the prescription had gone beyond the apothecary's control. When we note the ticklish balance of affinities between the atoms which compose the molecules of the synthetic drugs, we may see that there is great danger that an innocuous compound may be converted into a highly poisonous one by the slightest change in the number, kind, or relative position of these atoms, and this is just what chemical incompatibility means in connection with these drugs. The latest in this line comes from a correspondent of the London Lancet of September 28, 1889. This innocent individual states that he prescribed for a patient

suffering with painful rheumatism antipyrine with salicylate of soda, and was astonished after a few hours to find that the compound had resulted in the formation of a hygroscopic cream. Later he tried to mix antifebrine with salicylate of soda, and found that the two previously white powders now formed a pink powder. The writer wants to know what the changes are in these instances; whether new compounds are formed; if so, their formulae; and whether the pharmacological (*sic*) action of the drugs is betrayed by such combination. He says, further, that since he discovered the effect of the union of antipyrine with salicylate of sodium he has ordered the two drugs in solution. Whether he puts them both in the same solution, or exhibiting them in separate solutions, allows the patient to test their incompatibility in his stomach he does not say; but in any case it is a very dangerous tampering with drugs, the chemical compatibility of which has not been established.

It is to be hoped that some chemist will put these observations to the test and give the correspondent the desired information. It might be well, also, to suggest to him that this sort of chemical experimentation will some day kill its man by the development of a poison from the union of two non-poisonous compounds.

## SOMETHING NEW IN DRUMS.

At the recent meeting of the British Medical Association the Section of Otolaryngology was treated to a very original paper illustrating a new drum-head which promises to restore the hearing of a large percentage of the deaf. The instrument is the invention of Dr. John Ward Cousins, of London, who calls it "*The new audispheric artificial drum-head.*" "In shape it is exactly like a bat with a very high, tapering crown and a broad, flat brim, having a short ribbon attached to the edge." It is made of several sizes, according to the ear; it is designed to fit, is stained flesh color, and is so soft, light, and flexible as to produce no sensation of

weight or pressure in the canal. Its weight is from one sixth to one quarter of a grain. When in position the crown rests near the tympanic membrane (or where it should have been), the brim upon the meatal wall, and the ribbon or handle behind the tragus. It is made of compressed cotton fiber swollen by prolonged immersion in water, and saturated in an antiseptic oil and ether. Besides the above desirable qualities, it is claimed for the new drum that it can be put in position and removed by the patient himself, and that it can be successfully worn by persons whose ears are discharging any thing from fresh serum to fetid pus. In cases of this kind Dr. Cousins deodorizes the ear cavity with boracic acid, inserts the drum, and gives necessary instructions for future removal of the instrument and cleansing of the ear. He has tested the new device in more than a hundred cases of deafness from middle ear disease. Of these, three only failed to get decided improvement in hearing. The improvement in hearing is nearly always progressive.

#### THE BRITISH MEDICAL ASSOCIATION.

The British Medical Journal, for the last four or five issues, has devoted almost its entire great space to the proceedings of the fifty-seventh annual meeting of the British Medical Association, held at Leeds in August. The amount of work done in open session and in section was enormous, and the proceedings exhibit little that was not pertinent to medical doctrine, practice, or truth, while many of the papers and discussions were of high scientific value.

The English doctor rarely writes or speaks when he has nothing to write or say. His imagination, unlike that of the English poet, seldom "bodies forth the forms of things unseen," and his pen but rarely "gives to airy nothing a local habitation and a name." "With us 'tis not exactly so, but 'tis so in our song."

LOUISVILLE is a great educational center. Its many schools are thronged with students.

#### Notes and Queries.

THE TELEPHONE AS A CAUSE OF EAR TROUBLES.—As civilization advances, new diseases are not only discovered, but are actually produced by the novel agencies which are brought to bear on man's body and mind. The increase of insanity throughout the world is unquestionably due to the "storm and stress" of our crowded modern life, and almost every addition which science makes to the convenience of the majority seems to bring with it some new form of suffering to the few. Railway traveling has its *amari aliquid* in the shape of slight, but possibly not unimportant jolting of the nervous centers; the electric light has already created a special form of ophthalmia; and now we have the telephone indicted as a cause of ear troubles which react on the spir-its, and indirectly on the general health. M. Gellé has observed, not in women only, but in strong-minded and able-bodied men, symptoms of what we may call "aural over-pressure," caused by the condition of almost constant strain of the auditory apparatus, in which persons who use the telephone much have to spend a considerable portion of each working day. In some cases, also, the ear seemed to be irritated by the constantly recurring sharp tinkle of the bell, or by the nearness of the sounds conveyed through the tube, into a state of oversensitiveness which made it intolerant of sound, as the eye, when inflamed or irritable, becomes unable to bear the light. The patients, suffered from nervous excitability, with buzzing noises in the ear, giddiness, and neuralgic pains. In addition to these subjective symptoms, M. Gellé in some cases found objective lesions, such as a subinflammatory condition of the membrana tympani. A similar condition of things is often seen in persons who spend a large portion of their lives amid the jar and the crash of machinery. All the trouble speedily vanishes if the ear is allowed a sufficient measure of physiological rest. This it can only obtain by the cause of the evil being withdrawn. The victims of "telephone

tinuitus," if we may so baptize this latest addition to the ills that flesh is heir to, seem all to be of markedly nervous organization, and the moral may be drawn that such persons should not use the telephone. Mr. Edison has already done something to increase the plague of "nerves" which afflicts our generation, and if his brilliant career as an inventor is not cut short there can be little doubt that he will do yet more.—*British Medical Journal*.

**THYROIDECTOMY.**—Goitre is such a rare disease in the United States that the subject of its operative treatment is of but little practical importance for most of our readers. Nevertheless, the results obtained are so mysterious that perhaps a few words concerning them, as at present illustrated in the wards of Professor Theodor Kocher of the University of Berne, may not be devoid of interest. As is well known in the great majority of cases, myxedematous diseases after a time follow the complete removal of the gland. This Professor Kocher has found may be avoided by leaving in the neck one lobe or even part of a lobe of the gland. By means of careful antiseptics the operation is so robbed of its terrors that we have seen a patient, four days after it, entirely well, the wound being completely healed.

A very bold experimental operation for the relief of the myxedema which has followed complete removal of the gland is now under trial. It consists in inserting a fresh, healthy piece of the gland in the abdominal cavity, with the hope that it may form attachments and perform its mysterious function. In one case, probably by pressure upon the large intestines, the inserted mass, after the complete healing of the wound, caused such violent colicky attacks that it had to be removed, but in most instances no evil effects have followed the insertion. What becomes of the transplanted gland is not yet known. A case was recently shown us that had been operated upon three months previously, in which the presence of the gland in the abdomen could apparently be still demonstrated by palpa-

tion, etc., and in which the patient asserted his general condition was much better than before the abdominal section. It will be a very strange physiological fact if it should be found that the transplanted gland has the power of taking root and adapting itself to its new environment. It is, perhaps, allowable to add that the glandular masses for transplantation have been taken from the necks of individuals with hypertrophied thyroids.—*Therapeutic Gazette*.

**CINCINNATI LETTER.**—The Cincinnati Medical Society is again in full operation after the summer's vacation, as is also the Obstetrical Society.

Prof. C. W. Palmer, after a year's absence, is again at his post at the Ohio Medical College and the Cincinnati Hospital.

A very enjoyable reception was given by Dr. W. H. Taylor and his estimable wife to the American Association of Obstetricians and Gynecologists, on the evening of September 11, 1889.

The colleges, clubs, societies and medical matters in general are looking up, many of the doctors who have been away during the summer having returned and again taken up the prescription blank. The punnier who staid at home seems to look as well as his brother who haunted health resorts. Cincinnati has been remarkably comfortable the past summer.

A death from chloroform is again added to the list in Cincinnati. The unfortunate patient was a young man aged thirty-two. He was suffering from a crushed thumb. He applied to his physician, who readily told him that an amputation was necessary. To this the patient assented. The doctor called in another physician to assist him, who gave the chloroform, which was done in the patient's house. Hardly a compound of the anesthetic had been given when the patient was taken with convulsions and died almost instantly. Both physicians labored for more than hour to resuscitate the man, but all to no purpose. Death was due to paralysis of the heart.

The Cincinnati Hospital, while one of the

most careful, economical, and scientifically managed institutions of its kind in the country, is just now, and has been for the past few months, subjected to a series of persecutions which are abominable. The outs are howling for reform, and the truth is they are only wanting a chance at the perquisites themselves. One of the daily papers has been fighting the recently appointed superintendent ever since his appointment, although he has been an efficient and trusty officer of the institution for many years. Recently an expert book-keeper has been engaged to unearth matters, and while he may be very expert as a book-keeper, in many other things concerning hospital management he has proven himself rather pert than expert. While advising retrenchment, economy, and reform, he criticises the fact that *externes* are required to attend the hospital at their own expense. He thinks this excludes poorer students and those residing at a distance from competing. How much economy is there in feeding, bedding, and lodging six wild medical students for six months? He criticises the fact that while the librarian was formerly paid out of the library fund, he is now paid from the general fund. Had he inquired further he would have learned that a former employe of the hospital has added to his former duties that of librarian, which position he fills better than it has ever been before. He thinks it improper that a library for the sole use of physicians should be placed in a building built by general taxation. He queries, why not place this library in the public library? The answer is, that it would be far less accessible as far as the books were concerned, and as to the journals, they would be placed in the periodical room, which is so crowded with tramps and vagabonds that no physician would be comfortable, and scarcely safe, to read them. He cites the fact that there were no patients in the branch hospital for contagious diseases during 1888, and but one during 1887, yet two persons were paid for attendance there. He also wants to know why this farm of fifty acres does not help produce the food used in

the hospital. Were he as good a farmer as book-keeper, he would know that a farm of fifty acres left untenanted in the vicinity of Cincinnati would soon go to rack and ruin; and had he made inquiries, he would have found that this farm of fifty acres did contribute very substantially to the feeding of the inmates of the hospital.

A certain preacher who has his church arranged like a theater, who appears in the pulpit in a dress suit and patent leather pumps, and who is strictly sensational in his style, is interesting himself very much in the starting of a new free hospital for women. This patent-leather preacher, who would be called a quack if he was a saver of bodies instead of souls, goes about telling admiring audiences of the terrible high per cent of mortality in the Cincinnati Hospital in laparotomies. He, or his medical supply, runs the statistics back twenty-one years, to the time when abdominal section was made here by the general surgeon in the surgical wards with no fear of erysipelas or thought of antiseptics. The statistics of the Cincinnati Hospital for the few years past in this line are excellent, and it is very unfair to have a preacher and a lot of sympathetic women running about decrying the abdominal surgery of twenty-one years ago.

E. S. M'KEE, M. D.

SECRETION OF SWEAT IN ACUTE INFECTIOUS DISEASES.—Queirolo (*Deutsche med. Wochenschrift*, 1888, No. 48) has endeavored to determine experimentally how correct the view of the ancients is, that excretion of sweat plays an important rôle in the recovery from acute infectious diseases. He inoculated rabbits with the sweat of persons suffering with smallpox, malaria, typhoid fever, and rheumatism of the joints. He also made control experiments with the sweat of persons free from fever. All the rabbits inoculated with a sufficient quantity of the sweat of sick persons died within from twelve to forty-eight hours. Queirolo never demonstrated the presence of febrile symptoms or swelling of the spleen; in a few cases, nevertheless, there was a scanty serous or bloody serous effusion into the peritoneal cavity. In

the patients in question he artificially increased the production of sweat by means of dry heat. He believes that by this means he obtained only a favorable influence upon the issue of the infectious disease, as through profuse diaphoresis and the simultaneous administration of abundant quantities of fluids a washing of the injurious substances from the polluted organism is accomplished. Hence in the treatment of infectious diseases care should be exercised to have free diaphoresis.

**EXALGIN.**—According to the *Pharmaceutical Journal*, the aromatic series has given another analgesic, ortho-methyl-acetanilide, which, from its physiological effects, Prof. Dujardin-Beaumez has named exalgin, from ἐξ, out of, and ἄλγος, pain. Exalgin occurs in needles or in large white tablets, according as it is obtained by crystallization or from the mass after distillation. It is slightly soluble in cold water, more soluble in hot water, and very soluble in water containing a little alcohol. The analgesic effect of the chemical is produced by doses varying from three to seven grains. The effect is said to be very marked, and in all forms of neuralgia, including the visceral variety, is thought to be superior to that of antipyrin. Its toxic dose is ascertained to be 0.46 gram per kilogram (about 1-2,000 of body-weight of the animal), the phenomena being trembling and paralysis of the respiratory organs. Exalgin also possesses antiseptic and antithermic properties; but its anodyne action appears to be the dominant one.—*Dublin Journal of Medical Science*.

**POISONING BY SALICYLIC ACID.**—Dr. Pullmann states, in a communication to the *Berlin klin. Wochenschrift*, July 1, 1889, that while suffering with orchitis, the sequel of mumps, he was ordered by his attending physician to take seventy-five grains of salicylate of soda in one dose. The result was the production of vomiting and diarrhea, profound collapse, and hemorrhage from the nose. Dr. Pullman also states that four years ago he treated a case in which hemorrhage arose from or after the use of salicylic acid. A merchant, twenty-two years old, up to that time healthy, was attacked

with rheumatism of the joints. After the administration of ordinary doses of the salicylate intestinal hemorrhage occurred, which at first he did not connect with the employment of the remedy. After the attack had again become normal he employed the salicylate several times, and each time the next passage contained a profuse discharge of blood.

**ANOTHER BOGUS MEDICAL COLLEGE.**—It is reported from Portsmouth, N. H., that a bogus college of medicine has been found there, similar in management and larger in extent than the Druid College, at Maline a full report of which was made some years ago. This latest chartered institution is the Trinity University of Medicine and Surgery, having nominal headquarters at Besenlington, N. Y. Any person desiring to buy a diploma covering both medicine and surgery may have a choice of the following institutions, all of which exist merely on paper: University of Cazenovia, Montford Medical College, New York State Medical College, University of New Hampshire, Trinity University of Medicine and Surgery. The price of these bogus diplomas varies from \$50 to \$300.—*Medical and Surgical Reporter*.

**LONGEVITY OF WOMEN IN HUNGARY.**—Statistics collected by Fodor, and published in the *Deutsche med. Wochenschrift*, July 18, 1889, indicate that in Hungary the life of women is materially shorter than that of men. Up to the age of thirty years there are more women than men in the population; after this age the proportion falls from 102.7 per cent to 85 and 95 per cent at the ages of eighty and over eighty years. This condition is the opposite, he states, to that found elsewhere in Europe, where the proportion of living women to males is 105.5 per cent at thirty years of age, and rises to 144 per cent after eighty years.

**DEATH BY ELECTRICITY.**—Engineer Chas. F. Heinrich, who was asked to assist professionally the State authorities in the Kemmerling investigation, has written a letter to Mayor Grant in which he calls attention to the great sacrifice of human life caused by

the high voltage of electric light currents and the criminal carelessness of the companies who neglect to guard and maintain the proper insulation of their wires and apparatus. Since May 6, 1887, he states, seventeen persons have suffered instantaneous death by high voltage electric currents in the city of New York, while a great many others have sustained the loss of limbs or been otherwise permanently injured from the same source. The coroner's inquests in such cases have never brought out the facts as they should have done, and he calls upon the mayor to order an investigation as to the deadly nature of the high voltage of electric currents used in the city, and to cause police regulations to be framed which will prevent the further sacrifice of human lives from this cause.

**HISTORY OF MEDICINE.**—The Prussian minister of education, says Science, is turning his attention toward the study of the history of medicine, which seems to have been slowly dying out. There used to be a chair for this subject at every German university, but they have all become vacant with the exception of the one at Berlin, occupied by Professor Hirsch, the Nestor of the historians of medicine. To counteract this, it has been ordained that every newly-appointed professor of hygiene should give lectures on the history of medicine as part of his work.—*Boston Medical and Surgical Journal*.

**CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS.**—Dr. Weir Mitchell has been elected President of the next Congress of American Physicians and Surgeons, to be held in September, 1891; Dr. W. H. Carmalt, of New Haven, Secretary; Dr. J. S. Billings, of Washington, Treasurer; Dr. William Pepper, of Philadelphia, Chairman of the Executive Committee, and Dr. S. C. Busey, of Washington, Chairman of the Local Committee of Arrangements.

It is said that the practice of drinking cologne is becoming very common in Europe

and in this country, and, as an indication of this, that the sale of the perfume has increased greatly of late years. Women are more addicted to the habit than men, and a writer in the *Quarterly Journal of Inebriety* says that the presence of obscure and complex nervous disorders in a woman who uses cologne externally should always suggest the possibility of its internal use.

A PARISIAN medical society recently appointed a committee to consider the question of a universal language of science. The report of the committee was presented in the form of three questions, upon which the society voted as follows: "Shall a universal language be adopted?" "Yes." "Ought this to be one of the dead languages?" "No." "Shall it be the French language?" "Yes."

At the meeting of the American Pediatric Society, week before last, the following were elected: President, J. Lewis Smith; First Vice-President, A. V. Meigs, Second Vice-President, F. Forchheimer; Secretary, W. D. Booker; Recorder, W. P. Watson; Treasurer, C. W. Earle; Member of Council, L. E. Holt.

**AMERICAN PUBLIC HEALTH ASSOCIATION.**—The American Public Health Association will convene at Brooklyn, N. Y., Tuesday, October 22, 1889, at 10 o'clock A. M., and continue four days. The meetings will be held at the Brooklyn Institute.

### SPECIAL NOTICE.

**KATHARMON IN TREATMENT OF CHRONIC CYSTITIS.** By J. J. Norwine, M. D., Bismark, Mo. Katharmon, like many other new remedies brought to the notice of the profession, has been used and misused, condemned and praised before fair trial. I have been using Katharmon with the atomizer in the treatment of catarrhal trouble of the throat and nose, with better results than any other remedy, but especially do I feel thankful for its usefulness when I am called upon to treat subacute or chronic cystitis. I use 15-25-per-cent solution with previously boiled cistern water, and wash out the organ every other day, with most excellent and surprising results; Also, by means of absorbent cotton saturated with three parts Katharmon and one part glycerine, applied to irritable and itching piles, afford quicker relief than any remedy at the hands of the physician.

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNĀ."

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Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else. RYAN.

## Original Articles.

### THE ORTHOPEDICS OF INFANTILE PARALYSIS.\*

BY GEORGE W. RYAN, M. D.

*Clinical Lecturer on Orthopedic Surgery, Medical College of Ohio.*

The purpose of this short paper will be rather in the line of suggestion than that of argument, for before this body the need of mechanical treatment in infantile paralysis certainly calls for no words of commendation from me. However, although we admit this premise, it may be that through dissatisfaction with results in many cases, or with the heavy, ill-fitting apparatus of the shops, or with the difficulty in securing any appliance, it is probable that many practitioners have abandoned mechanical support altogether, with the belief that under the conditions above stated the support may be even worse than useless; in fact, harmful. It is probable, also, that many practitioners, because of the infrequency of such cases, do not have the time and do not care to acquaint themselves with the proper method or direction of making a good support, and endeavor to treat the child without this adjuvant.

There are a few practitioners, I am aware, who condemn all mechanical supports in this condition, no matter how skillful the surgeon may be in this department. But a few months ago I heard an intelligent physician say that it had been shown (by whom

he did not state, nor could I learn by questioning him) that orthopedic measures in infantile paralysis were really harmful. But I am not here to argue this question for I believe it admits of none. These views and conditions that have been pointed out are cited for the simple purpose of showing that they lead up, in the unfortunates who suffer from this disease, to the most distressing deformities, and are responsible for a large proportion of the crippled to be seen on the streets of any city. That a very considerable number of these cripples come from the very poor is true, and the neglect in many of them may be charged to ignorance or carelessness of the parents; but that many more of them become so through careless advice is none the less true. It will be understood, of course, that these remarks apply to paralysis of the lower extremity, for in the few cases where the upper extremity may be involved, support of body weight being out of the question, and tendency to deformity being very slight, the question of mechanical aid may be considered *sub judice*.

The most common deformity of infantile paralysis is the acquired club-foot, and this deformity grows greater as the mechanical support is delayed. In fact, in the beginning there is no contraction in any of the muscles of the palsied limb, but in time the healthy muscles begin to assert their power against their weakened fellows, and as a matter of course contracted tendons result, and subsequent talipes. Attempts at walking under this condition tend to the greater displacement of the tarsal bones and to contraction of the fibrous tissues of the plantar region. The result is a typical clubfoot. Frequently that most troublesome type of talipes, calcaneo valgus, is the result.

\* Read before the Mississippi Valley Medical Association, September, 1889.

Contraction of the hamstring tendons and of the flexors and external rotators of the hip-joint follows, or, again, the internal rotators at the thigh contract, and then we have a marked genu valgum with a varus or valgus. This is no exaggerated picture of the patient when mechanical treatment has been delayed in a case of some months' standing. That proper surgical and mechanical treatment will correct this, goes without the saying; that it will, if used at the proper time, prevent it, is easily demonstrated and more easily performed.

Aside from the prevention of deformity, let us take up the question of mere support. What is a more painful sight than to see a partially paralyzed child struggling along, with the characteristic limp of infantile paralysis, without an apparatus or a crutch? The awkward, laborious attempt to lift the flabby limb involves the expenditure of more than double the muscular energy of a normal child in walking, and this exercise is of no benefit even to slightly paretic muscles, for nature then calls on none but those on whom she can rely. Does the surgeon, after removing the dressings of a fractured thigh, tell his patient to go about without crutch or cane? If he did, would not the patient almost instinctively reject such advice? He feels too well the weakness of his limb, and knows that for a time it would be impossible without support. The surgeon advises support here, not to prevent deformity, but to enable his patient to get about easily until sufficient strength is regained to discard the support. So it is with the infantile paralytic. The support accorded the child by crutches enables it to get about, but it gives only aid in locomotion, and does really nothing to improve the partially palsied muscle or to prevent muscular contraction and subsequent deformity. A carefully constructed appliance on a child with infantile paralysis who has arrived at the walking-age is always indicated, therefore, even if there be a paraplegia so great as to preclude walking for several months, for the reason that it will certainly prevent contraction of the

healthy muscles. And when, with time and electricity and massage, the child has reached that period when it may attempt locomotion, the appliance is a very great aid, for if it be properly constructed and intelligently applied it will give the weakened muscle an opportunity for moderate exercise, while it controls and limits the action of the healthy muscles, which tends to contraction. The principles which govern its application are dictated simply by reason and common sense, viz., to give exercise to the weakened muscle at the expense of the healthy one, and to develop as much as possible the normal relation of one group of muscles to their antagonists. Hence it will be useful as an adjuvant to electrical treatment, as it keeps paralyzed muscle in a position where it may acquire the greatest benefit from local dosage.

Another point that deserves a few words is the degree of comfort and improved gait and appearance. Certainly the laborious gait with an effort requiring so much muscular force is greatly lessened.

Regarding the weight of apparatus, a matter of very great importance, it may be laid down as a rule that it should be as light as is possible with the strength required. Weight is not a matter of such importance in the appliances used in joint diseases, for it often adds to the traction necessary—a not undesirable thing in a hip case. The prejudice against heavy apparatus is not altogether a just one. But, in the condition we are treating of here, matters are altogether different. The appliance is to be a support, an aid, and it should be made as light as possible. The surgeon can, by a little persistency, soon disabuse the mind of the conservative instrument-maker of many of his somewhat old-fashioned fancies. But even worse than the heavy appliance is one that is often applied under the pretense of getting a close fit, and consequently a less conspicuous appearance. It is the laced or binding appliance that is fitted closely to the limb by means of hard leather bands, and tightly laced over it at thigh and calf. These have done more harm, I believe, than the heavy,

awkward appliances, harmful as they may have been. The damage is not alone from the interference with the circulation, although that is bad enough, for it is a necessity that a palsied limb should have no more than its own abnormal congestion; but it is the degree of muscular atrophy that these bindings and lacings produce. The arrest of atrophy is the one great object of the early treatment, and such appliances tend only to its rapid increase. Under no circumstances should they be used.

As the case progresses to improvement—and they do improve despite the views of some surgeons, although it may be months or perhaps a few years—the amount of support may be lessened and the patient permitted to get about with a shorter appliance. This is done with the purpose of encouraging the patient to depend more and more upon himself. Many cases, however, reach a certain amount of improvement very early, and almost surely all of them shortly before puberty, when no farther gain can be reasonably hoped for. In the marked ones the support then becomes a necessity in so far as it is a comfort and a cosmetic, and its use then becomes a matter of a life-time.

In the older patients with contracture—though this term may not be a happy one, it expresses a condition which we readily understand—apparatus will be of little service unless applied after the division of tendon and fascia. And even in the simpler cases the knife does better service than any attempt at stretching, for it does it at once without the prolonged discomfort generally attending a stretching process by mechanical means. Physiologically and theoretically the division of a tendon may be wrong and followed by weakness. As a matter of fact subsequent weakness of a divided tendon or muscle is a rare event.

The use of some support following such division is a necessity in order to prevent the return of the condition. The question may be summed up in the following conclusions:

1. That orthopedic treatment, in conjunction with local treatment of muscles, is use-

ful in all children who have arrived at the walking age, by reason of the support it gives, and that it prevents deformity.

2. That it tends to preserve in a measure the proper balance between antagonistic groups of muscles, in that it aids the weakened group and restrains the normal one.

3. That by this means it gives the paralytic group the benefit of any movement they may be capable of, and in this way can they get exercise.

4. That it certainly can correct deformity.

5. That a heavy appliance, or one adjusted by lacing bands to the leg or thigh, does more harm than good.

6. That such measures are a necessity in the after-treatment of divided muscle or tendon.

7. That in most contractions it is better to divide than to stretch them.

CINCINNATI, OHIO.

## MODERN TREATMENT OF PULMONARY PHTHISIS.\*

BY C. F. M'GAHAN, M. D.

*Late Physician to Sanatorium of Allen, S. C., and Hot Springs, N. C.*

Since the discovery of Koch was made known in April, 1882, observers all over the world have been seeking for the germicide that was to kill the tubercle bacilli without injury to the lung tissue in which they thrive, and scarcely a medical society has met in the past decade that some member has not tried to give new ideas concerning the treatment of this much discussed yet unsettled subject. Hence I beg you will bear with me should I repeat things you all know, as I will endeavor to show the great number of specifics that have been vaunted, and their value.

Dr. George T. Welch,<sup>1</sup> in reviewing the treatment of phthisis, showed that one hundred years ago it was managed by blood-letting frequently repeated, gentle emetics of ipecac., out-door exercise, expressed oils, opiates, ripe fruit, low diet, laxatives, blia-

\*Read before the Massachusetts Medical Society, September, 1889.

<sup>1</sup>Journal American Medical Association, Dec. 21, 1887.

ters, setons, issues, and friction. In the same paper he stated that sixty years ago it was treated by the lancet, digitalis, mercury, blisters, setons, and antimony, mercury being carried to pytalism. This practice was continued till about 1841. From that year till Koch's discovery appeared the generally adopted treatment was cod-liver oil, blisters, tonics by some, while others still used bleeding.

As early as 1838 Dr. Debove<sup>2</sup> declared in his clinic at the Hôpital de la Pitié that, consumption being due to the presence of a parasite, its proper treatment was to be directed to the extermination of the parasite.

The treatment by respirators was begun about 1880, and was strongly advocated by such men as Mackenzie, Beverly Robinson, Tyndall, and several other observers from different parts. Many styles of respirators were offered to the public, each constructed upon the plan of the Blake-Mackenzie, and on the sponge through which the air passed before reaching the mouth, was put such volatile substances as eucalyptus, terebene, thymol, etc.

My experience with respirators has been quite extensive, having seen them used for eight years; and having used them myself for the past four years, I must say that each year I grow stronger in my conviction that the opinion I expressed of them in 1882 was correct, namely, in pulmonary phthisis the main benefit to be derived from respirators is the systematic expansion of the chest, and not from the substances placed on the cotton or sponge. Give a patient an oronasal respirator with suitable fluid to put on the sponge, at first have him use it ten to fifteen minutes at a time, and when he becomes accustomed to it he can use it from three to five hours a day. During the time patients are using it they naturally take deep inspirations and prolonged expirations, drawing the air as far as possible into the lungs, and it is this gymnastic performance which does the good, and not the substances on the sponge.

<sup>2</sup> Virginia Medical Monthly, July, 1887.

Dr. Solomon Solis-Cohen<sup>3</sup> stated he had excellent results from inhalations of terebinated substances in phthisis, especially when they were associated with peroxide of hydrogen.

Dr. J. B. Richardson,<sup>4</sup> of Louisville, informs us that Dr. Girtamer, a physician, in the year 1796 used carbolic acid [rock oil], and hydrogen gas by inhalation. So we see this treatment has nothing new.

Intra-pulmonary injections were advocated by Dr. Pepper<sup>5</sup> in 1874, and later by Drs. Beverly Robinson,<sup>6</sup> Guggenheim,<sup>7</sup> of Paris, J. Blake White, Riva,<sup>8</sup> of Pavia, R. Singleton Smith, of England, Leo Rosenbuch,<sup>9</sup> of Hamburg, and others. Dr. Beverly Robinson reported cases benefited by the intra-pulmonary injections of Lugol's solution. But it is due to the articles of Dr. J. Blake White, which appeared in the Medical Record, May 22, 1886, and November 13, 1886, that interest in the treatment was revived, and his careful report of cases induced others to try this method. Dr. Riva, of Pavia, recommended the withdrawal of the needle while injecting the fluid, so the whole lung around the diseased portion will be bathed. The principal agents used were carbolic acid, wood creosote, iodoform, and eucalyptus. In cases of cavity, if we can gauge accurately the thickness of the chest wall, and can put the point of the needle in the center of the cavity, I think we may hope for some good results from the use of intra-pulmonary injections, by the healing of the cavity; but in all other stages of the disease I think this form of treatment is not only contra-indicated, but fraught with great danger, and I am glad to say it is almost obsolete at the present day. While speaking of inhalations, it will not be amiss here to review the hydrofluoric-acid treatment which was first advocated by M. Didiergeon in 1862, and was afterward revived in 1885 by MM. Seilers and Garcia,<sup>10</sup> the two last

<sup>3</sup> Journal American Medical Association, July, 1887.

<sup>4</sup> Medical Record, July, 1887.

<sup>5</sup> American Journal Medical Sciences, Oct. 15, 1887.

<sup>6</sup> Medical Record, Nov. 20, 1886.

<sup>7</sup> British Medical Journal.

<sup>8</sup> *Gazzetta Degli Ospitali*, March 23, 1887.

<sup>9</sup> *Przegląd Lekarski*, Nos. 5-6, 1888.

<sup>10</sup> London Lancet, Oct. 15, 1887.

asserting that the immunity from consumption of workers in glass factories has long been known, and they cite several cases to prove their theory. Their treatment was to convey air (which had been passed over a mixture of one part hydrofluoric acid and three parts of water) into a chamber suitably fixed to receive it, and in that chamber have the patient sit with his clothes protected from the acid, the air to contain at first ten liters of acid to each cubic meter, and the proportion gradually to be increased. This treatment was indorsed by Dr. Gager, of Arco, near Gastein, Dr. Charles Jarjavay,<sup>11</sup> Dr. E. Goetz, MM. Herard, Fereol, and Proust.<sup>12</sup> The Academy commission reported that it was able to nullify the growth of tubercle bacilli, and upon the whole indorses the experiments of MM. Seilers and Garcia. So hydrofluoric acid was fast pressing itself into the front rank of the therapeutic measures to control this disease when the article of MM. Grancher, and Chantard<sup>13</sup> showed, after careful experiments, that hydrofluoric acid had no power to destroy the tubercle bacilli, and only lessened its virulency; still the virulency remained just the same. Dr. Ludwick Polack,<sup>14</sup> in a paper before the Buda Pesth Medical Society, believes hydrofluoric acid is hurtful in every case. Personally, I have had no experience with this treatment, but I fail to see in what cases it would do good. Far better is the treatment by sulphurous acid, which was advocated by the French physicians some two years ago. Dr. Darien,<sup>15</sup> in giving the history of the sulphurous acid treatment, says that it had been used as early as the second century. Dr. Sollard came upon it accidentally. Dr. Dujardin-Beaumetz believes there is some good in this treatment. During a recent visit to Charleston, S. C., where there are several large phosphate works, which necessitate their burning a great amount of sulphur to make the sulphuric acid, I found, upon inquiry from the superintendents of the different mills, that the sulphur burners were

peculiarly exempt from pulmonary trouble, though it was the main cause of sickness among their workmen not working in the sulphur rooms, owing to the dirty occupation and dampness of climate which are particularly fruitful of this disease.

It is only necessary that I mention the subcutaneous use of such drugs as eucalyptus, iodoform, carbolic acid, and say that even those who advocate this method of treatment do not claim that it diminishes the bacilli in the sputa. With our present views as to the relation of the bacilli to the cause of phthisis, any treatment that will not lessen the bacilli in the lungs can not be said to hold an important place in the therapeutics of this disease.

The Bergeon treatment came to the medical profession from its inventor, August, 1886, and no measure was ever so universally accepted by the profession, and roused so much interest among the laity. Within six months it was indorsed by no less men than Cornil, Morel, Dujardin-Beaumetz, Bennett, Hamon, Fougeray, and in this country by Solis Cohen, Henry T. Bruen, and many others. To mention the Bergeon treatment to day is simply to show how enthusiastic the most conservative of our physicians became over a measure which was destined in a few months to sink into oblivion. Iodoform has been used for some time in this trouble, combined with creosote, and alone. My favorite way of using it is to dissolve it in sulphuric ether, then add alcohol and water, and cause the patient to inhale the spray of this through a globe inhaler. In this way I have derived some benefit from iodoform, but I can not say that I like giving it by the stomach.

Tannin in large doses for pulmonary consumption was introduced to the profession by Drs. Arthand and Raymond,<sup>16</sup> of Paris, about September, 1886. Dr. C. DeViti Demareco<sup>17</sup> recommends it highly. Dr. E. Houze,<sup>18</sup> of the Hospital St. Jean, Brussels, prefers it, after one year's trial, to all treatments now in vogue. For myself I have

<sup>11</sup> *Bull. Gen. de Therap.*, March, 1888.

<sup>12</sup> *Therapeutic Gazette*, Jan. 1888.

<sup>13</sup> *Journal de Médecine et de Chirurgie Practique*, July, 1888.

<sup>14</sup> *London Lancet*, March, 1888.

<sup>15</sup> *Bull. General de Thérapéutique*, t. CXI-44.

<sup>16</sup> *Medical Record*, July 14, 1887.

<sup>17</sup> *Revue Médicale*, June 11, 1888.

<sup>18</sup> *Medical Record*, March, 1888.

not had the hoped for results, and after repeated trials I have been obliged to abandon it.

A novel treatment was brought to the notice of the congress of Russian physicians at Moscow, January, 1887, by Prof. Kremjanski,<sup>19</sup> of Charkou. His specifics are aniline, antifebrine, and meat-powder specially prepared. This treatment has not been adopted to any extent in this country, and the Russian physicians have criticised it very severely, some claiming it to be positively injurious. Prof. Kremjanski published in the early part of this year a book, in which he says he is more firmly convinced than ever of the benefit of his treatment, and now adds iron to it. Time alone will decide whether his treatment has merit or not.

The creosote treatment was originated by Drs. Buchard and Gimbertas<sup>20</sup> as early as 1877, and Frantzel,<sup>21</sup> in 1887, claims that he has used it since 1878, chiefly in cases without cough, fever, and complications, and reports, out of 400 cases treated,  $37\frac{1}{2}$  per cent were permanently benefited. In the same year Dr. Somerbrodt,<sup>22</sup> of Breslau, reported 5,000 cases of pulmonary tuberculosis treated with creosote; 27 per cent recovered, mostly in the first stage. In 1888 von Bruen<sup>23</sup> published an account of 1,700 cases he had treated in eight years, with good results. Dr. Bogdanivitch<sup>24</sup> writes that he gave in four months four ounces and two drams of pure creosote, which was  $15\frac{2}{3}$  drops a day, with an improvement in all of the symptoms. Following this suggestion, in treating my patients last winter I increased the dose very rapidly, and soon had one patient taking 14 drops of pure beechwood creosote a day for nearly one month, with general improvement in symptoms. My plan is to begin by giving  $\frac{1}{4}$  of a drop of creosote in a tablespoonful of water three times a day, and gradually increase this until the maximum amount that the patient can bear is reached, watching at the same time the stomach, and

upon the slightest sign of irritation lessening the dose of creosote for the time.

Though creosote in most cases acts as an aid to digestion, I have found several patients who could not take it at all, and after repeated trials of small doses had to give it up entirely, the main trouble being the irritation it caused to the stomach. Taking all things into consideration, creosote is one of the best medicinal agents we have at the present day for pulmonary phthisis, and I believe with the globe inhaler its external use will greatly help its internal administration. Favorable reports are being received from observers located in different parts of the country who have tested it, and, though it is not a cure-all, I regard it as one of the most important remedies we have to baffle with this disease, especially in its early stages.

Guaiaicol was recommended by Dr. Sahli<sup>25</sup> on account of it constituting 60 to 90 per cent of creosote, and it has been indorsed by Drs. Schuller, Horner, and Frantzel. I have used it and find patients with an irritable stomach will be able to take guaiaicol when creosote could not be borne. I prefer to give it in spirits and water, though Dr. Horner, of the hospital at Zwickan, gave it in pill form. However, I regard its position as secondary to creosote.

Dr. Louis Halter,<sup>26</sup> in speaking of the immunity of workers in lime from phthisis, concludes by attributing it to the dryness of air and elevation of temperature; and though the temperature of  $37^{\circ}$  to  $38^{\circ}$  C. in the lungs is the best for the production of the bacilli, yet when it was raised higher they did not thrive so well.

Dr. Louis Weigert,<sup>27</sup> independent of Dr. Halter, finds that bacilli outside of the body die at  $11^{\circ}$  C., and published an article in Medical Record, December 15, 1888, in which he describes at length his apparatus for bringing air to the required temperature, giving directions how to take the inhalations, and then cites five cases. Dr. E. L. Shurely, of Detroit, presented a paper on the Hot Air Treatment, at the fortieth meet-

<sup>19</sup> Medical Record, March 28, 1888.

<sup>20</sup> Medical Record, April 21, 1888.

<sup>21</sup> Journal American Medical Association, Nov., 1887.

<sup>22</sup> Journal American Medical Association, Oct., 1887.

<sup>23</sup> Journal American Medical Association, April, 1888.

<sup>24</sup> Medical Record, June 9, 1888.

<sup>25</sup> London Lancet, Dec., 1887.

<sup>26</sup> Berlin *Klin. Wochenschr.* No. 38, 1888.

<sup>27</sup> Medical Record, December, 1888.

ing of the American Medical Association, at Newport, June 25, 1889. He simply reported progress with eight cases, and says his patients could not stand the extreme heat that the German physicians claimed they used. Dr. Karl von Ruck<sup>28</sup> relates the manner in which his experiments were conducted with the apparatus, in order to show that the air at the mouth piece is not as hot as is generally supposed. He says, in conclusion, "When the inspired air is at 280° F the sensation of heat in the mouth, throat, and trachea becomes almost unbearable, provoking severe cough." "The rubber mouth-piece became so hot it could not be held between the lips but for a few respirations at a time." Out of thirteen cases he only saw improvement in two, and in cases of tubercular ulcer of the larynx positive harm.

Theoretically, this would seem the ideal germicidal treatment, but we have already some objections to it, and we will have to await further experiments in order to determine its value.

Dr. O. H. Presby,<sup>29</sup> of New York, and Dr. E. Liciga,<sup>30</sup> of Mexico, have revived the use of mercury, the former by inhalation, the latter by the internal use of calomel in large doses. Both claim good results.

So far I have given the antiseptical treatment of phthisis as it has been practiced since the discovery of Koch to the present day, omitting only such minor agents as have had scarcely any support.

Of all forms of treatment there is none which has demanded so much consideration from the profession as the climatic, and there is no doubt as to its being by far the best single means we have at our command; but as all our patients have not the means to make the change of residence, we will need other measures for those who are compelled to remain at home. In Dr. C. T. Williams and Dr. Allbutt, of England, and Dr. Dennison, of America, we find the staunchest advocates for high altitudes. The paper of Dr. Dennison, read before the Ninth International Medical Congress, is one of the strong-

est that has been written upon this subject, and is destined to be of inestimable value to the general practitioner as an aid in selecting a suitable climate for his pulmonary cases. Having had the misfortune, about nine years ago, to be taken down with pulmonary phthisis, and being able to go to any climate that I thought would be beneficial, I tried several resorts in different parts of the country, and the result of my observation was that for the greater number of sufferers from pulmonary phthisis the climate we want is a moderately cold and dry one, though it may not have the altitude. Such a point I found in Aiken, S. C., where I was a resident physician of Highland Park Hotel. My experience makes me opposed to sending patients to the sea coast, or as far south as Florida, except they be in the last stages of the disease, when the salubrious climate of Florida may make them survive a few months longer and die quietly; but in such cases I think home is the best place, where they can be surrounded by friends and every comfort their means will admit of. For the first stage of the disease I consider a winter residence farther south than Aiken, S. C., to be injurious. For the summer months Asheville will be found to agree with the largest number, though for winter I regard it inferior to several places farther south. I have not touched upon the climate of Colorado, for nothing can be said concerning it that Dr. Dennison has not mentioned, and I simply advise the reading of his articles.

The main organ we must guard is the stomach; and no matter what course of treatment we pursue, the moment we notice that it is causing a disturbance with digestion it must be stopped, at least till the digestion has regained its tone, when it may be tried again; but if upon repeated trials we find it disagrees with the stomach, no matter how great our faith in it may be, we had better cast it aside. A patient with good digestion and nutrition in the first stage of this disease ought with proper treatment to recover from it. I therefore believe in tonics, and have derived benefit from the syrup of hypophosphates of lime and soda given both

<sup>28</sup> Therapeutic Gazette, August, 1889.

<sup>29</sup> Therapeutic Gazette, June, 1889.

<sup>30</sup> Medical Record, July, 1889.

separately and together. Cod-liver oil I give to the few whose stomachs are strong enough to stand it, but on account of its tendency to cause digestive trouble my use of it is confined to a very limited number of cases. The different forms of malt I have used with good results. With suitable tonics for each case, and a carefully selected nutritious diet, with the addition of creosote in those who are able to take it, we will find the greater amount of fresh air insisted upon and the minimum amount of medicine given the better.

Digestive troubles will be best combated by a carefully regulated diet, and by giving a small amount of nourishment frequently. Peptonized milk has been one of our most valuable articles of food in many cases, but we will find some patients who can not take milk, and for them the juice squeezed from a freshly broiled steak will answer a like purpose. When it is found necessary to prescribe medicine to control the trouble, we have numerous brands of pepsin and pancreatin, which we can combine as we see fit with bismuth and aromatics.

Fever will be best combated by rest, phenacetine, antipyrine, and antifebrine; but unless the fever rises above 101° F. I scarcely do any thing more for it than keep the patient quiet during the time of the expected rise. As the disease gets better the fever will gradually decrease.

Night-sweats in the milder form will be controlled by some nourishment just before retiring and about the middle of the night; when that fails we will have resort to sage tea, sulphuric and gallic acids, and in the more severe cases to belladonna and even sulph. atropia hypodermically. I have tried agaricine, but with no success.

Cough, which is at times so distressing as to cause loss of sleep, can be controlled by one fourth of a grain of codeia in syrup lactucarium in the early stages, but the dose will have to be increased as the patient becomes used to it. Chloroform I have found very useful in all stages, but eventually morphia will have to be resorted to, which, once begun, must be gradually increased.

Hemoptysis, when it occurs, can be best treated by rest on the back with head and shoulders elevated, gallic and sulphuric acid, ergot, ol. erigeron, turpentine, and opium. Acetate of lead I have found too severe on digestion. Sometimes it will be found necessary to use ice on the side. The heart at this time will have to be controlled with digitalis or strophanthus.

In conclusion, I would advise you once more to care for the stomach. Keep it in a healthy condition, and you will find improvement in your patient, but allow it to become disordered, and in a very short time the patient will lose the good he has gained in months. Give as few medicines as possible, so as not to put too great a tax on the digestion, and remember the medicinal treatment is secondary to the hygienic.

#### A CONVENIENT AND COMFORTABLE DRESSING FOR FRACTURE OF THE BONES OF THE HAND.\*

BY GEORGE F. BEASLY, M.D.

Injuries of the hand, occurring so often among the wage earners, demand from us that we use our utmost skill in the treatment, that they may recover with the least deformity, and at the same time the appliances should be the most simple and comfortable.

These injuries usually result from direct violence, which produces laceration of the soft parts. The dressing should be of a character that will permit bathing or application without destroying their efficacy.

But little of practical benefit can be gleaned from the authorities on surgery, most of them passing these injuries with few remarks, as though the matter were trivial instead of demanding the most careful attention.

But some of the principles laid down in the treatment of fractures in other portions of the body can be applied here.

It is a well known fact that the best re-

\* Read before the Mississippi Valley Medical Association, September 12, 1889.

sults in the treatment of fracture are obtained when the injured limb, after the reduction is accomplished, is placed in the position it naturally assumes when at rest. Hence, one of the most comfortable as well as convenient dressings of the fractured humerus is the Stromyer pillow, filling as it does the angle between the chest and the arm. In fracture of fore arm, placing and retaining it in a drawn position with supination; fracture of lower extremities, either in the flexed or extended position. The hand at rest and flexed, the palmar surface concave in all directions or inclosing a complete sphere. Acting on this hint, I have been using for some time in fractures of the hand, for a palmar splint, an ordinary rubber ball, such as is sold for children with which to smash the family mirror and bric-a-brac.

Plug the opening, and if the ball does not completely and snugly fit the flexed hand, cover it with absorbent cotton, jute, or, what is better, marine lint.

Then, after putting the fractured bones in proper position, place the ball in the palm and flex the fingers and thumb around it; then, using a roller about one and a half to two inches wide, snugly bandage them in place. At first I used a dorsal splint of gutta serena or card board, but found this was superfluous and often annoying, it being the only part of the dressing of which the patient complained.

The advantages of this dressing over the straight splint are: It is more comfortable and more easily borne; is not inconvenient and in the way as when a finger is extended and rigid, catching on every obstacle and rendering life a burden to the sufferer.

In case there is partial ankylosis it is much easier to restore the function of a flexed finger than an extended finger, and if there should occur complete ankylosis the flexed condition is not a serious hinderance in labor.

In some cases there is more or less comminution and slight overlapping in these. The bow, if any occurs, will be on the dorsal

instead of the palmar surface, and will not impair the flexing of the finger.

If only the ulnar side is injured the dressing can be so applied as to leave the thumb and index finger free, and if it is the right hand the sufferer can use the hand in writing, eating, etc.

LAFAYETTE, IND.

## Societies.

### LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

Stated Meeting, August 30, 1889, J. M. Ray, M.D., President, in the chair.

Dr. D. W. Yandell exhibited a patient who, twenty-four years before, had been circumcised. He now has two fistulous openings into the urethra. The meatus is intact, and the patient urinates through three openings.

This is one of the possible accidents of circumcision.

Dr. Yandell also exhibited a pathological specimen representing cancer of the penis, with photos illustrating the appearance of the organ before and after operation by Dr. I. N. Bloom, who was associated with the speaker in the management of the case. History: A man aged forty-eight contracted syphilis at twenty-one. The disease ran the usual course. He had been the subject of phimosis, for relief of which the flap operation was done in 1860.

The present growth involved chiefly the prepuce, which was edematous. The frenum was as broad as a finger. There was a nodule under the foreskin. On the upper and lower surfaces of the glans there was considerable ulceration, partly hidden by the foreskin. The sore had constantly secreted a thin sanious fluid. Diagnosis: epithelioma. This diagnosis being verified by the microscope, Dr. Yandell advised amputation of the penis, which he did three days ago. The organ was transfixed by two bent pins forming letter *x*, after the method of Morrow. The under flap was left about one eighth inch longer than the upper flap. The skin was stitched all around and made to

cover as well as possible the corpora cavernosa. No rise of temperature followed. There is no incontinence. The patient makes water without trouble. The history of epithelioma of the penis is singular. Some hold the disease to be most malignant in this situation; others that cancer here is less malignant than elsewhere. The disease is most frequent between the ages of forty-five and seventy. Cancer is more likely to be seated on the prepuce than on the glans. Cancer may show itself as nodules in the corpora cavernosa. The cause alleged to be most frequent is congenital phimosis. There is possibility of infection through coitus from uterine cancer. This etiological factor is denied by many observers.

Prognosis: Death in thirty-four months after inception, if life be not prolonged by an operation. (Hayes.)

If this be done there is often no recurrence for several years. In operating Albert prefers the knife. He refers to fifty cases treated by galvano-cautery, in which there were eight cases of pyemia. Unless the inguinal or lumbar glands are involved, the cautery may be successfully employed for extirpation.

#### DISCUSSION.

Dr. W. L. Rodman: My personal experience with this disease has been gloomy. All patients on whom I have operated, or seen operated upon, have died within two years. I saw my first case under the elder Gross. The patient was a man about fifty years old. The glans is affected. He was operated upon, and died in two years. The second case I saw with Dr. H. K. Pusey. The glans penis was involved. The sore was of about six months' standing. The penis was amputated. The patient died within six months. If the growth be situated around corona glandis, glandular involvement occurs early; if elsewhere, later. Epithelioma in this situation is certainly a very grave trouble. Prognosis is far less favorable than when the lip or rectum is involved.

Dr. J. A. Larrabee saw, last March, a man with ulceration of the lip, supposed to be cancerous—irritation the cause. He sub-

mitted a section of the lip. It contained a piece of brass.

Dr. Yandell referred to a case of trephining done on a boy, June 27th, for epilepsy. He had had no return of the disease. He has changed in every respect for the better, especially mentally. There was no projection on under surface of the bone. A circumscribed exudation produced the pressure. The boy had received a blow on the head two or three years ago.

Dr. William Bailey reported a case of puerperal convulsions treated successfully by elimination. Pregnancy of eight months. There was suppression of urine and edema of the extremities. The development of convulsions in such cases are opposed to interference with gestation if it can be avoided. The catheter was introduced into the womb, but failed. Croton oil was the chief cathartic employed. Chloral in full doses was given by rectum. The symptoms disappeared, and the woman is likely to go to term without further trouble.

Dr. Cecil said it was an important question, whether we should induce premature labor under these circumstances. In some cases convulsions are due to the presence of the child in the uterus. If we can clearly demonstrate the fact that the convulsions are due entirely to pregnancy, we should lose no time in evacuating the uterus. If due to other causes (uremia, for instance) we may hope to save the mother and the child by the prompt use of antispasmodics and eliminatives.

Dr. J. W. Irwin: In my judgment the proper treatment is to empty the womb. Give free hypodermic injections of morph. ( $\frac{3}{4}$  to 1 grain) and chloroform for immediate results. Eliminative treatment is too slow. I think it a mistake to let a woman go to term when the trouble is at the eighth month.

Dr. Anderson: I claim that I have popularized the eliminative treatment in Louisville. We should treat the convulsions and let the pregnancy go. Fifteen years ago I treated a case on the eliminative principle only. If labor is going on, I think it proper practice to hasten it. When labor is not

going on the practice is improper. Chloral, bromides, and free catharsis are called for. Two cases have been reported to this Society in the last two years wherein large doses of morphine had been given hypodermically with no good results. I think morphine in the last stages of pregnancy, when there is kidney insufficiency, does positive harm; morphine should be avoided, because it checks elimination.

Dr. Yandell: The objection to morphine, which obtained so long in uremic conditions, was ably answered by George Johnson in the *London Lancet*. He urged its use, and declared that he had never seen it do harm. The fact that the doctor had seen no deaths is valuable, but not conclusive. There are convulsions that may be successfully treated and convulsions in which no treatment does good.

Dr. Rodman referred to two cases of puerperal convulsions treated by calomel—two grains every fifteen minutes; thirty-four hours after there was free purgation. One patient recovered; both were bled; chloral, bromide, and croton oil were used; morphine was given as a last resort.

Dr. Simpson: I once saw a case in which convulsions occurred every fifteen minutes. Half grain of morphine was given every half hour. The patient died. Eliminative treatment was not tried.

Dr. Bailey, closing the discussion, said:

Dr. Irwin said: Elimination is too slow. I will answer by asking if artificial labor may not be too slow. Morphine does hinder elimination by the kidney. The cases reported by Dr. Rodman show that elimination had been produced before the morphine was used; very free purgation had been induced. In all cases there is irritation, reflex and central, which morphine may allay. I admit that the trouble is not always due to faulty elimination. We are enabled to lessen the amount of poison in the system by action upon the skin, bowels, etc. I believe that chloral is competent to induce sufficient sedation in all cases. By elimination in almost any case, at seven or eight months, I believe the patient may be saved.

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## Correspondence.

### PARIS LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

The discovery of the marvelous effects resulting from the administration of the testicular fluid of animals has not even the merit of being a novelty, as may be seen by the following note which was reproduced in the *Journal des Connaissances Médicales*. The note referred to is taken from a book on boar hunting which was published by Elzéar Blaze in 1838. Here the author gives indications as to the manner the animal should be skinned and cut up when it is killed. He laid stress on the advice to cut up the testicles. "If I tell you to cut up the testicles, I do not mean by this that they should be thrown away, as they may be useful to you later on. If you take it into your head to marry at an advanced age, the testicles of a boar dried, reduced to powder, mixed in the bouillon made from an old cock, and swallowed on an empty stomach by yourself and your wife, children will be born to you every nine

months, and you will be obliged to seek a receipt to restore things to their former state." The following is a receipt taken from the works of a learned doctor: "*Magna est uxoratis inquietudo, et animi perturbatio prole sterilesque existere: propterea, ut tanto infortunio liberentur prolemque habeant, per aliquot dies jejuno stomacho vir et uxor cum jure galli veterus testiculorum apri in umbra exsiccatorum pulverem capiant; profecto brevi tempore optatum adipiscuntur, ut in multis sterilibus ex quacum que causa non semel expertum est. (Julii Cæsaris Baricelli à Sancto Mario, doctoris medici Hortulis Genialis. Genovæ, 1620.)*"

There is now a perfect rage for congresses in Paris, for since the opening of the Exhibition there has been one held on almost every conceivable subject in medicine and its collateral sciences. Not the least important is that on Otology and Laryngology, at which Dr. Miot read a very interesting paper on one of the causes, hitherto little known, of deafness. This cause has no other origin than a sort of ankylosis of the little bones of the ear which lie behind the tympanum, and which prevents their proper function. Dr. Miot concludes that a cure is very often obtained in rendering the "stirrup" more mobile, by means of a small operation which offers no danger whatever for the patient and does not determine suppurative inflammation whenever antiseptics is rigorously carried out.

There exist pluviometers, thermometers, barometers, dynamometers, but we have had no "acoumeters" to measure the auditive power of an individual, as his muscular power can be measured. Dr. Lichtwitz, of Bordeaux, has found it in Edison's new phonograph. Phonographs, being apparatus of identical construction, will reproduce with the same intensity and the same thrill the different sounds adopted as acoumetric scales, and it will be easy to estimate the auditive power of an individual according as he will perceive such and such degree of the scale. Dr. Lichtwitz suggests that this instrument will find its place particularly in the consulting-rooms of specialists for diseases of the ear.

Dr. Lannois, of Lyons, has also occupied himself with an invention of Mr Edison, but

this time it is to find fault with it. He accuses the telephone to produce certain perturbations in ears already more or less abnormal. The following are the conclusions of the author: (1) The employment often repeated of the telephone does not appear to have any grave inconveniences for healthy ears, but it is injurious for ears presenting a previous lesion. (2) The troubles which it determines consist above all in the diminution of the hearing by fatigue of the auditive attention, buzzing and other subjective noises, cephalalgia, vertigo, nervous hyperexcitability and even temporary psychological troubles. (3) These accidents, often temporary, disappear when one gets accustomed to the apparatus. In all cases it ceases completely with the cessation of its employment.

Another subject that has been treated of at the Congress is Neuroses of Nasal Origin. The speaker recalled that a certain number of nervous maladies, such as facial neuralgia, convulsive tic, spasmodic cough, have no other cause than a previous malady and the more frequently unrecognized of the nasal fossæ. A proper treatment of the affection of the nose is sufficient to cure the nervous malady.

Dr. Koch, of Luxemburg, read a note on the advantages of tracheotomy in certain cases of laryngeal phthisis. Tracheotomy, he said, practiced according to certain indications procures the prolongation of life for several years, it prevents most frequently unforeseen accidents, such as death by suffocation, etc. As tracheotomy is an operation very grave and hazardous, it has been proposed to replace this by "tubage," which consists in the introduction into the larynx of a metallic tube, giving free access to the passage of the air. Dr. Egidi, of Rome, proposed conclusions contrary to this procedure, declaring that tracheotomy is far superior as regards results and convenience.

At a recent meeting of the Academy of Sciences a printed memoir was presented by M. Milne-Edwards, in the name of M. Certes, on the Protozoaires of the Mission of Cape Horn. In this work the author asserts that there are no pathogenic microbes to be found at Cape Horn. The Fuegians did not know any thing of smallpox, measles, scarlet fever, and diphtheria. Before the arrival of the Mission they

did not even know what pulmonary phthisis was. Tuberculosis commenced to establish itself since 1881 in that country. From the above and following considerations the question suggests itself as to whether the extension of civilization is really a blessing or otherwise, and whether savages should not be allowed to live in their blissful ignorance. It is known that the inhabitants of Africa, particularly negroes, are passionately fond of spirituous liquors. In order to justify themselves, they say that this vice was acquired from the white race. Drunkenness is now to be observed almost generally in the five parts of the globe. Even Mahometans who were so strict in the observance of all that issues from the Koran, and which forbids among other things the use of fermented drinks, now lay aside the salutary rules of their bible, for it is not an uncommon thing to see a drunken Turk.

PARIS, Sept. 17th, 1889.

### Abstracts and Selections.

**ATROPINE IN ENURESIS.**—In December, 1888, Dr. Simon Baruch, of New York, read a paper before the Pediatric Section of the New York Academy of Medicine, in which he made such positive statements about the value of atropine in enuresis that I at once resolved to try its efficacy upon similar cases in my private practice as well as in the public institutions with which I was connected. While the length of this paper, with the time at my disposal, will not permit me to go into the various causes and the different modes of treatment of enuresis, I shall simply content myself at this time in detailing the results obtained in the thirty cases treated in this empirical manner.

The following formula was used in all the cases, viz:

Atropiæ sulph.....gr. i;  
Aq. destillatæ..... ʒi. M.

Of which one drop for each year of the age of the child was given at four and seven o'clock in the evening. It was found by actual counting that the ordinary medicine-dropper held eighty drops of this liquid.

I. Mary B., aged ten, has always had nocturnal enuresis, and for the last two years diurnal also. On January 5, 1889, she took ten drops of the solution at four and seven o'clock in the evening, and did not wet her

bed that night, and has not since then had any difficulty in retaining her urine during the night or day.

II. James E., aged nine, has had nocturnal and diurnal enuresis since an attack of scarlatina when four years of age. He was circumcised when six years of age, but with only temporary benefit. Meatus inflamed. He was given nine drops of the solution twice every evening for a week, with alleviation of the diurnal symptoms, but no apparent effect on the nocturnal symptoms. In the beginning of the second week (January 13, 1889) the doses were doubled, that is eighteen drops were given at the usual hours in the evening, and that night, for the first time in five years, he did not wet the bed, and has not done so since, the medicine being discontinued the following day.

III. John E., aged six, a brother of the preceding patient, has always been troubled with nocturnal enuresis, and has received the usual routine of supposed appropriate remedies without apparent improvement. Prepuce elongated but easily retractable. The above solution was prescribed in six-drop doses twice a day, and after the first dose there was marked improvement, and at the end of the first week he was cured.

IV. John B., aged eleven, has always had nocturnal but no diurnal enuresis. Prepuce normal; meatus inflamed. After the sixth day's use of the solution his mother brought him to me and said that he was well—wetting the bed less after the first day, scarcely any after the second, and not at all after the third; and now, after six months' interval, there has been no return of the disagreeable symptoms.

V. John C., aged six, has always had nocturnal and diurnal enuresis. Prepuce normal; meatus inflamed. After the third day's use of the drops his mother reported that he had not wet the bed at night or his clothes during the day since the first day's doses.

VI to XXIX were treated in the orphan asylums of Jersey City, where such cases are kept in separate beds, and are taken up every night about eleven o'clock, urged to urinate, and their clothing, if soiled, is changed. The previous habits, general surroundings, and mode of living before entering the asylum are usually unhealthy, and it is found that cases of nocturnal enuresis are cured by the hygienic and dietetic changes met with in these asylums without medicinal treatment.

VI. Valentine S., aged twelve, has had nocturnal enuresis as long as he can remember. Prepuce elongated but easily retract-

able. The usual doses of the foregoing formula were commenced on January 15, 1889, and continued until February 14, 1889, with impaired vision on January 17th and 18th only, and remittent cessation of the nocturnal symptoms, frequently going three or four nights without disturbance, when he left the asylum on February 14th.

VII. Louise McK., aged six, has been two years in the asylum, during which time she has had nocturnal and diurnal enuresis.

January 14, 1889. The regular doses at stated intervals were given, with the result that she was cured as far as the diurnal symptoms were concerned, and would frequently go two or three nights without the nocturnal occurrence, and then they would resume for a night; possibly two, and then disappear. On February 14, 1889, the doses were doubled, and she had no return of the symptoms until June 15, 1889, when the nocturnal symptoms again became intermittent, following an attack of measles.

VIII. Joseph P., aged six, has been three years in the asylum, during which time he has had nocturnal enuresis. Prepuce elongated but easily retractable; meatus normal.

January 15, 1889. Began the usual doses of formula at the stated intervals, with the result that every once or twice a week did the symptoms return until February 14, 1889, when the doses were doubled, and the symptoms have not since returned.

IX. Gus M., aged seven, has been one year in the asylum and thinks he has always wet the bed at night. Prepuce elongated, tight, but retractable with the use of a little force; meatus inflamed.

January 15, 1889. Began the usual doses at stated intervals, but without cessation of the symptoms until February 14, 1889, when the doses were doubled, and since then he has had no recurrence of the symptoms.

X. James B., aged eight, has been four years in the asylum, during which time (previously he does not remember) he has had nocturnal enuresis. Has a tight phimosis, which is not retractable.

January 15, 1889. Began usual treatment with cessation of the symptoms for one night in a week until February 14, 1889, when the doses were doubled, and since then there has been a recurrence of the symptoms about two nights in the week.

XI. William M., aged nine, has been four years in the asylum, during which time he has had nocturnal enuresis. Has hypospadias.

January 15, 1889. Usual treatment, with intermission of two or three nights in suc-

cession, until January 30, 1889, since which time there has been no recurrence.

XII. James M., aged four (a brother of Case IX), has been one year in the asylum, during which time he has had nocturnal and diurnal enuresis. Prepuce elongated but retractable; meatus normal.

January 15, 1889. Usual treatment began, with the result that his diurnal symptoms were cured, and a remission of the nocturnal symptoms, that is, he would wet the bed one night and then not for two nights, and again he would wet the bed for two or three nights in succession and then not again for several nights, until February 14, 1889, when the doses were doubled; but since then he wets the bed on the average of about twice a week.

XIII. Mary R., aged four, has been in the asylum three months. Has always had nocturnal enuresis.

January 15, 1889. Usual treatment, resulting in a cessation of the symptoms for over one half of the time, until February 14, 1889, when the doses were doubled, and after the first day there has been no return of the symptoms.

XIV. Irene D., aged three, has been only three days in the asylum, but the history obtained by the sister in charge is that she has always had nocturnal and diurnal enuresis.

January 15, 1889. Usual treatment, resulting in an immediate cure of the diurnal symptoms and an intermittent cessation of the nocturnal symptoms until February 14, 1889, when the doses were doubled, and she has had no return of the symptoms (nocturnal or diurnal) since.

XV. James A., aged twelve, has been one year in the asylum, and says he has always had nocturnal enuresis. Prepuce elongated but easily retractable; meatus normal.

January 15, 1889. Usual treatment, resulting in a complete cessation of the symptoms on January 31, 1889, and they have not since returned.

XVI. Bernard S., aged fifteen (brother of Case VI), has always had nocturnal enuresis. He was circumcised in early childhood without permanent results.

January 15, 1889. Usual treatment (only one dose daily, however, on account of his absence from the asylum during the day), with the result that he would go one or two nights during the week without a recurrence of the symptoms, until February 10, 1889, when he left the asylum.

XVII. Frank McC., aged five, has been two years in the asylum, during which time he

has had nocturnal and diurnal enuresis. Prepuce elongated and tight, but can be retracted with a little force.

January 15, 1889. Usual treatment, resulting in an immediate cure of the diurnal symptoms, and a remission of the nocturnal symptoms, that is, going two or three nights without wetting the bed and then a return of the symptoms, until February 14, 1889, when the doses were doubled, since which time he has had a recurrence of the symptoms about two nights in twelve weeks.

XVIII. John T., aged six, has always had nocturnal and diurnal enuresis. Prepuce normal; meatus inflamed.

January 15, 1889. Usual treatment, resulting in a cessation of the diurnal symptoms after the third day, and of the nocturnal after two weeks.

XIX. Henry D., aged five, has been in the asylum one year, but has always had nocturnal and diurnal enuresis. Prepuce elongated but easily retractable; meatus inflamed.

January 15, 1889. Usual treatment, resulting in immediate cure of the diurnal trouble with remissions of the nocturnal, until February 14, 1889, when the doses were doubled. Since the 16th of February there has been no recurrence of either symptoms.

XX. Charles S., aged eight, has always had nocturnal enuresis. Prepuce elongated but easily retractable; meatus normal.

January 15, 1889. Usual treatment, resulting in a remission of the symptoms, until February 14, 1889, when the doses were doubled, since which time he has had a recurrence of the symptoms about two nights in the week.

XXI. Joseph S., aged eight (twin brother of Case XX), has always had nocturnal and diurnal enuresis. Prepuce elongated but easily retractable.

January 15, 1889. Usual treatment, resulting in an immediate cure of the diurnal symptoms and a remission of the nocturnal, until February 14, 1889, when the doses were doubled, and since the third day of their use there has been no return of the symptoms.

XXII. James T., aged three, has been six months in the asylum, during which time he has had nocturnal and diurnal enuresis. Prepuce elongated but easily retractable; meatus inflamed.

January 15, 1889. Usual treatment, resulting in a cessation of the diurnal symptoms after the third day, and a remission of the nocturnal symptoms until February 14,

1889, when the doses were doubled, and since the 16th of February there has been no return of the symptoms.

XXIII. Michael H., aged six, has been three years in the asylum, during which time he has had nocturnal and diurnal enuresis. Prepuce elongated but easily retractable; meatus slightly inflamed.

January 15, 1889. Usual treatment, resulting in the immediate cure of the diurnal symptoms, with marked remission of the nocturnal symptoms, until February 14, 1889, when the doses were doubled, and since February 16, 1889, there has not been any return of the symptoms.

XXIV. William T., aged twelve, has been over six years in the asylum, during which time he has had nocturnal enuresis. Prepuce and meatus normal.

January 15, 1889. Usual treatment, resulting for the first three days in pains in the forehead with dimmed vision, but after that they passed away and a gradual remission of the nocturnal symptoms until January 31, 1889, since which time there has been no return.

XXV. Susan D., aged eleven, and Case XXVI, Mary H., aged twelve, have always had nocturnal enuresis.

February 5, 1889. Usual treatment for each, with the astonishing results that they have not had a recurrence of the symptoms since that day. The treatment, however, was continued during the 6th, 7th, and 8th of February, when it was discontinued. On the 7th and 8th they each complained of pains in forehead and impaired vision, which entirely disappeared in a day or two.

XXVII. Nancy C., aged fifteen, and Case XXVIII, Josephine C., aged thirteen, have always had more or less diurnal enuresis, which, however, entirely ceased after the first daily doses of the solution (February 10, 1889), and has not since returned. Case XXVIII complained of a fullness in her forehead the following day only.

XXIX. Honora B., aged nine, has always had nocturnal and diurnal enuresis.

February 10, 1889. Usual treatment, resulting in an immediate cure of the diurnal symptoms and of the nocturnal after the fourth day of treatment.

XXX. John M., aged seven, has always had nocturnal enuresis. Prepuce and meatus normal.

February 10, 1889. Usual treatment. February 17, 1889, mother reports that he has not wet the bed since the third night after taking the medicine.

From a careful review of these thirty un-

selected cases I am justified in saying that we have a remedy in sulphate of atropia, given to its full physiological effects, which is unequalled in our materia medica.—Dr. William Perry Watson, *Archives of Pediatrics*.

**RUMINATION IN MAN, OR MERYCISMUS.**—Dr. Paul Gallois has lately had an opportunity of studying gastric digestion, by keeping under his observation for some time a mérycole—that is to say, a human being who ruminated. The patient was a man, aged thirty, in good health. In 1882 he had a very mild attack of typhoid fever. Some time afterward he noticed that shortly after a meal his food came up in mouthfuls from his stomach without nausea and he instinctively masticated the fragments and swallowed them again. He could not say for certain when he first took to ruminating; this is the rule with mérycoles, who often, after due thought, remember that their habit existed during their childhood. Dr. Gallois' patient grew tired and disgusted of his ruminations, and cured himself by discouraging the regurgitation of food, and eating but sparingly at each meal, confining his dietary to substances easy of digestion. Large meals had always been followed by free regurgitation, and the least digestible substances were the most freely brought up into the mouth. Without any further treatment this patient cured himself of his ruminating habit, and has not indulged in it for a year. Dr. Gallois studies this case in a paper published in the *Revue de Médecine* last spring. The "cud" brought up first after a meal included samples of every thing swallowed. This did not confirm Kuss's theory that liquids pass straight into the duodenum along a supposed channel made by muscular contractions of a tract of the walls of the stomach. The first "cud" was red like wine and smelled of wine; thus liquids must remain in the stomach for some time with the solid ingesta. Later, the cud became true chyme; then solid pieces of undigested salad-leaves, gristle, etc., came up with the chyme; lastly, solid fragments of this kind were alone regurgitated. If the patient swallowed them they were thrown up again, and he often spat them out to save trouble; yet if unable to do so, as when in society, he managed to chew them up so fine that at length the stomach sent them on into the duodenum. The patient had no dyspeptic symptoms. The phenomenon of rumination in his case did not show that the stomach (as Blanchard supposed) had the power of selecting indigestible matter and

throwing it up. Were that theory true, such matter would have come up first, and with pain or nausea; in this case it remained until it came up without any more digestible material. Again, this case seems to prove that the cardiac orifice of the stomach is insufficient in a mérycole, and probably has no selective power in any subject. On the other hand, the case indicates that the pylorus has that power, though in a purely mechanical sense. The sphincter is resistant and contracted at the beginning of digestion; then it lets liquids, next grumous material, and lastly solids through into the duodenum. In cases of dilatation of the stomach, the fluid contents are expelled with difficulty into the small intestine. No dilatation existed in Dr. Gallois' case. In normal digestion the evacuation of the stomach continues, no doubt, throughout digestion, and does not take place suddenly and completely at one stroke, but gradually, the most solid ingesta passing last.—*British Med. Journal*.

**DEATH FROM SUBLIMATE IRRIGATION AFTER ABORTION.**—Seven years since, Tarnier introduced the practice of washing out the vagina with weak corrosive-sublimate injections. The results proved satisfactory, and the injections came into vogue in German and English as well as in French lying-in hospitals, extending freely into practice. Like every thorough method of counteracting deadly agencies in the human organism, sublimate irrigation is not free from danger; and although it greatly reduces the death-rate and proportion of puerperal fever cases in long series of labors, some cases of mercurial poisoning will occur in those series, notwithstanding the most careful administration of the remedy. In this country Drs. Dakin and Boxall have published very minute observations on mercurialism under the above-noted conditions. They appeared in the *Transactions of the Obstetrical Society* for 1886 and 1888. Dr. Legrand read before the Anatomical Society of Paris, in April, a case of twin abortion, retained placenta, and death from acute mercurialism. Between the birth of the first and second child, ten liters of a 1 in 2,000 solution of sublimate were employed to wash out the uterine cavity, twice at an interval of three hours only. Immediately after each injection of sublimate a two-per-cent solution of boracic acid was thrown up into the uterine cavity, but sublimate had been several times employed for vaginal injection. After the extraction of the second child the boracic solution was injected into the uterine cavity.

The intra uterine injections were discontinued, and boracic and carbolic solutions were used for the vagina. A day later gingivitis, salivation, colic, and dysentery set in, and carried off the patient in five days. The kidneys were large, pale, and very edematous; they contained mercurial salts in solution. The palate was ulcerated; the esophagus, stomach, and small intestine healthy. The mucous membrane of the entire large intestine was covered with eschars and ulcers, most marked on the summits of rugae. The ulcers began in the cecum, were least abundant in the transverse colon, and most marked toward the anus. The above conditions have been noted in many other cases of death after sublimate irrigations in childhood. The kidneys were diseased. Keller, of Berne, has already pointed out the danger of mercurial irrigation when these organs are not healthy. The English authorities just quoted both dwell on this danger. Dr. Legrand relates that the ulcerated intestinal mucosa swarmed with bacteria. This fact, he adds, must make us despair of insuring intestinal antisepsis by means of corrosive sublimate.—*Ibid.*

**PIL. SALINE CHALYBEATE TONIC (FLINT'S).**  
In the New York Medical Journal, May 18, 1889. Prof. Austin Flint, M. D., speaks very highly of the following formula as a tonic in Bright's disease, and also in simple anemia, stating that he has given it in nearly every case in private practice, in which a chalybeate tonic was indicated, for some time past, and in only one case out of thirty-five did it fail to cause marked improvement. Prof. Flint states, also, that in five cases of Bright's disease, of which he has notes, this formula was the only medicinal remedy employed. In all cases the tonic seemed to exert an influence on the quantity of albumen in the urine. Dr. Flint's formula is as follows:

Sodii chloridi (C.P.).....	3iij;
Potassii chloridi (C.P.).....	gr. ix;
Potassii sulph. (C.P.).....	gr. vj;
Potas-ii carb. ....	gr. iij;
Sodii carb. (C.P.).....	gr. xxxvj;
Magnes. carb. ....	gr. iij;
Calc. phos. precip.....	5ss;
Calc. carb.....	gr. iij;
Ferri redacti. ....	gr. xxvij;
Ferri carb.....	gr. iij.

M. In capsules, No. 60.

Sig: Two capsules three times daily, after eating.

In the great majority of the cases of anemia, etc., in which iron was strongly indicated, the

tonic seemed to act much more promptly and favorably than the chalybeates usually employed. In a certain number of cases in which patients stated that "they could not take iron in any form," the tonic produced no unpleasant effects.

This formula is now furnished by Parke, Davis & Co. in pill form, and reprints of Dr. Flint's article from the New York Medical Journal will be sent to doctors indicating their wish for them.

**THIRIAR ON VENTRO-FIXATION OF THE UTERUS.**—Dr. Thiriar publishes in *La Clinique* an instructive clinical lecture delivered to his class at the Hôpital St. Jean, Brussels, on Ventro-fixation for Prolapsus Uteri. The term he proposes to use for the operation is "hysteropexy," from *hystero* (the uterus) and *pexy* (fixation). The condition of the patient, an elderly woman, who had been suffering from complete prolapsus for the last eight years, was such as to render all exploratory and operative procedures *per vaginam* difficult in the extreme, as she had ankylosis of the left hip, the thigh being fixed in an adducted position. There was a good deal of pain, and the uterus was visible on the outside of the vulva even when the patient was lying down. Pessaries had been tried, but were productive of no benefit. Under these circumstances it was determined to perform hysteropexy. The abdomen was opened in the linea alba between the symphysis and the umbilicus, and the uterus drawn forward and fixed to lips of the wound by three points of strong catgut suture, an iodoform dressing being subsequently applied, which was renewed in a week's time. Seventeen days from the time of operation the wound was healed, and the uterus could be felt high up and firmly fixed, so that the patient might be considered cured. She was, however, kept in bed for three weeks longer, when, the uterus being still firmly fixed, she was allowed to get up. Unfortunately, a fortnight later the prolapsus returned, but no pain or dragging was felt. The only thing to be done was to give her a cup pessary and to discharge her as incurable. In his remarks upon the case Dr. Thiriar points out that the operation is a new one, and a good deal more experience is needed to determine the best method of performing it. He does not think Carcava's plan of cutting down to the peritoneum and suturing the parietal and visceral layers of the peritoneum together a particularly practical one, as it prevents exploration for adhesions and removal of uter-

ine appendages if necessary. The plan adopted in this case was that of Leopold, except that catgut was substituted for silk, and no scraping of the epithelial layer of the peritoneum for the purpose of assisting the formation of adhesions was practiced. The difficulty of fixing the uterus permanently to the abdominal wall is considerable. Müller, of Berne, who amputates the uterus and sutures the stump to the lips of the abdominal wound, has found the adhesions break down and the prolapsus recur. Altogether Dr. Thiriar is not disposed to view hysteropexy with much favor—at all events, when performed by itself—though he thinks there may be cases where the prolapsus is accompanied by hypertrophic elongation of the cervix by rectocele or systocele, where, as an adjunct to some other operative measure, it may prove of value. He suggests that the chances of obtaining a permanent adhesion between the abdominal wall and the uterus would be increased by treating the uterus as Juffier treats the floating kidney—that is, by peeling off the peritoneum from a considerable surface, which is then sutured to the abdominal wall. A lesson which this case teaches is, not to be in too great a hurry to publish results. Had this case been published four or five weeks after the operation, hysteropexy would have been credited with a success which would have been entirely unwarranted.—*London Lancet*.

**TRANSMISSION OF MICROBES TO THE FETUS.** The question of the possibility of the direct transference of the virus of infective diseases from the maternal to the fetal organism has, since the recognition of the apparent dependence of such diseases upon the presence of microbes, given rise to more than one series of experiments and some interesting clinical and pathological observations. Among the latter is a case recorded by Eberth (*Fortsch. d. Medizin*, 1889, No. 5), in which the possibility of such transmission of the typhoid bacillus was raised. It was the case of a young woman who, in the third week of an attack of typhoid fever, aborted at the fifth month. The fetus was expelled within its membranes intact, and macroscopically appeared normal; but in the blood, and in fluid expressed from the spleen and lungs of the fetus, there were found typhoid bacilli (recognized microscopically and by cultivation), which also occurred in the intervillous spaces of the placenta. Drs. Eug. Fraenkel and F. Kiderlen (*Ibid.*, No. 17)

record a very similar case, in which, however, the abortion (also at the fifth month), though occurring in the third week of an attack of typhoid, was associated with acute peritonitis, found to be due to an ovarian abscess and double salpingitis. The placenta, fetal blood, and spleen were examined for typhoid bacilli, but with a negative result. On the other hand, cultures of staphylococcus pyogenes were obtained from the spleen. This case harmonized with some others where there was a similar absence of the typhoid organism in the fetus; but it is pointed out that in all these cases the placenta was normal. It would seem (as in Eberth's case) that the placenta must be diseased for such transference of pathogenic organisms to take place, and the occurrence of hemorrhage in the placenta appears to be a favorable condition for the transference. In this case, however, although typhoid bacilli were not transmitted, septic organisms were derived doubtless from the suppurating foci in the mother, and probably caused the death of the fetus from septic infection. Fraenkel, about two years ago, injected subcutaneously cultures of the bacillus typhosus into three guinea-pigs. Two of them died in three days. They were both pregnant, and the fetal part of the placenta was found to be hemorrhagic. The placenta and the fetuses yielded abundance of the microbes. There have been other and contradictory observations on this subject of the transmission of microbes from mother to fetus; some asserting it to be usual, others that it requires special favoring conditions. Netter found pneumococci derived from the mother in a seven-months fetus; Tizzoni and Caltani found comma-bacilli in the blood and serum of a five-months fetus. The observations are, however, too scanty to permit as yet of the formulation of any definite notions on the subject.—*Ibid.*

**THE MIASMATIC THEORY OF ACUTE RHEUMATISM**—To most practitioners acute rheumatism must appear essentially a personal or constitutional ailment, occurring most readily under certain unfavorable conditions, such as fatigue, exposure, depression, with wet or cold weather. There is a disposition, however, among some physicians to regard it as dependent essentially on miasmatic conditions. One of the latest expositions of this view is to be found in a paper read before the German Medical Society of New York by Dr. Leonard Weber, and contained in the New York Medical Record of August

31st. Dr. Weber considers it nearly proved by the labors of Immermann, Edlefsen, Friedlander, and their pupils, that what he calls inflammatory rheumatism, and what is generally termed acute rheumatism, is not produced by taking cold, that is, refrigeration of the heated surface of the body; but that it belongs to the class of miasmatic infectious diseases assuming an epidemic-like character at certain times, in so far as we are apt to see a larger number of cases when there is decreasing rain and moisture, while with an increase of the same the number of cases is diminished. Among other points he considers as nearly proved that rheumatism is also a house disease, the subsoil of houses in certain locations being infiltrated with virus, which, after prolonged dryness, may be set free by the air currents carried into the apartments. In masked forms of rheumatism there may be an absence of one or other of the main symptoms of the polyarthritis. Neuralgia of the trigeminal, sciatic, spinal accessory, or other nerves, with slight febrile movement, may be of a rheumatic nature, and yield to alkaline and salicylate treatment after other remedies have failed. Dr. Weber says that his records show that the greater number of his cases of polyarthritis rheumatica occurred in February and March, and again in the hot and dry summer months. We do not commit ourselves to the theory of the miasmatic or external origin of acute rheumatism. By the way, Dr. Weber does scant justice to our own countryman, Dr. MacLagan, who must be chiefly credited with this theory, which, indeed, led him to the use of salicin. We incline strongly to the personal and constitutional theory of its origin. But it is well to keep all well-argued theories in view. It is satisfactory to note that Dr. Weber regards the salicylate of soda, which he gives generally with the bicarbonate, as standing in foremost rank of valuable drugs with which modern chemistry has presented us — *Ibid.*

INCUBATION PERIOD OF LEPROSY. — Käng reports the case of a man, thirty-two years of age, who, when he was sixteen years old, came from Sweden into Norway. In 1876 he associated with another servant, who was a leper, and who had open ulcers on the lower extremities, and who a year afterward died of leprosy. He shared a room with this man, and sometimes slept in the same bed with him. He ate and worked with him. For nine years afterward he was perfectly well, when in August, 1886, after a chill, he de-

veloped febrile symptoms which kept him three weeks in bed. He again appeared to be quite well, when in June, 1887, he had symptoms of conjunctival catarrh. In August of the same year he developed febrile symptoms and unmistakable symptoms of leprosy. The author considers that as leprosy developed in a healthy man, the son of healthy parents, who came from a country where there is no leprosy, the disease must have been communicated to him, and he assumes that the time of communication was when he lived with the leper. There was thus an incubation period in this case of nine years — *British Medical Journal*.

UTERINE TUBERCULOSIS. — An interesting case of primary tubercular disease of the fallopian tubes has occurred in Professor Lebedeff's wards. The patient, who was the widow of a man who had died of phthisis, was of a cachectic appearance and suffered from amenorrhea. On examination, a firm, nodulated, intra-abdominal tumor was made out, situate in the space of Douglas. An attempt was made to remove the tumor, but had to be given up as disseminated miliary tubercle was found affecting the peritoneum. The intestines and the uterine appendages too were all matted together. Six weeks after the attempted operation the patient died with symptoms of general tuberculosis. At the *post-mortem* examination miliary tuberculosis was found affecting the peritoneum, the lungs, the pleura, the colon, and the mucous membrane of the uterus. Both the fallopian tubes were dilated and filled with pus, the epithelium in parts being absent. The intensity of the destructive process was greatest in the tubes, and became less marked toward the periphery. In sections tubercle bacilli were found; there was no tuberculosis, however, in the ovaries, and only the mucous membrane of the uterus was affected. — *London Lancet*.

THE VALUE OF CAFFEINE IN ADYNAMIC CONDITIONS. — In spite of the continued endeavors of Dr. Huchard, of Paris, to demonstrate to the medical profession the value, and simultaneously the harmlessness, of large doses of caffeine, still there seems to be a prejudice against the drug and a ruling idea that its free use is likely to produce unpleasant cardiac symptoms. New remedies, of doubtful efficacy, that are springing up daily, find no lack of advocates, while many comparatively older drugs do not receive the attention that their curative properties warrant. This is Huchard's com-

plaint, as he once more brings to the notice of the profession the value of large and repeated doses of caffeine in all adynamic conditions. As an example of its efficiency, Huchard, in the *Therap. Monatshefte* for August, cites the case of a gouty man who was suffering from a right sided pneumonia, and who, twelve days later, developed an inflammation of the left lung. The patient fell into a condition of extreme adynamia, and collapsed. During the following thirty days Huchard gave this patient 95 hypodermic injections of caffeine, of 4 grains each, 51 injections of ether, and 19 of trinitrin. The result of the treatment was satisfactory beyond all expectations. The author quotes five cases in which the value as well as the harmlessness of the drug in large doses is clearly demonstrated. He employed it in four other cases of pneumonia; in such instances "the disease is in the lungs, but the danger is in the heart." Huchard does not hesitate to employ subcutaneous doses as high as 31 to 48 grains. The reported efficacy of daily doses of 3 to 5 grains is entirely illusionary.

Dr. Huchard's experiments upon animals proved that the drug acted upon the central nervous system before it influenced the heart. There is, therefore, a marked difference between the action of digitalis and caffeine. Digitalis affects primarily the heart, caffeine the nervous system.

In conclusion, the author asserts:

1. That the great value of large doses of caffeine, given subcutaneously, in all adynamic conditions is unquestionable.
2. That large doses of caffeine are entirely harmless.—*Med. News.*

**ANTISEPTIC ACTION OF CHLOROFORM AND OTHER VAPORS.**—Dr. Segall has published, in the *Münchener Medicinische Wochenschrift*, an account of some observations in which he has been engaged with the object of determining the amount of antiseptic action possessed by the vapor of chloroform, of formaldehyd, and of creolin. The method employed was to infect the jelly (previously liquefied) in a test-tube with the particular microbe under investigation. After the infected jelly had been allowed to solidify, a small tube containing chloroform, creolin, or a ten-per-cent solution of formaldehyd was suspended over it, so that the surface of the jelly should be exposed to the action of the vapor given off, the mouth of the test-tube being closed with a well-fitting plug of cotton wool. The greatest effect was produced by the vapor of chloroform,

this being found to have a nearly equal effect on all the different bacteria experimented on, these including staphylococcus pyogenes aureus, bacillus prodigiosus, and the bacilli of pneumonia, of typhoid, of anthrax, of cholera, etc. The upper part of the jelly remained clear and free from microbes, while the deeper layers presented evidences of the existence of numbers of colonies. In the tubes containing formaldehyd, though only in a ten-per-cent solution, there was also a great difference between the superficial and deep layers; while, when creolin was employed, this difference was much less marked, though the antiseptic action was greater than that of the fumes of carbolic acid, which have been shown to exert no preventive action on jelly cultures of the cholera microbe.—*London Lancet.*

**COCAINE TABLETS.**—These tablets are now largely used by careful physicians for extemporaneous preparation of any desired strength of cocaine solution. The rapid deterioration of cocaine solutions make these tablets a necessity.

To make a two-per-cent solution of cocaine: In one fluid dram of water dissolve one cocaine tablet,  $1\frac{1}{2}$  grain. To make a four-per-cent solution of cocaine: In one fluid dram of water dissolve one cocaine tablet,  $2\frac{1}{2}$  grains. To make a ten-per-cent solution of cocaine: In one fluid dram of water dissolve five cocaine tablets,  $1\frac{1}{2}$  grain: or dissolve two  $2\frac{1}{2}$  grain and one  $1\frac{1}{2}$  grain tablets in one fluid dram of water. Parke, Davis & Co. guarantee the purity and anesthetic efficiency of their cocaine product, and will send samples of their cocaine tablets to physicians if desired.

**COCAINE-POISONING.**—Dr. Vinogradoff gives, in the *Ejenedelnaya Klinicheskaya Gazeta*, an account of the *post mortem* examination in a well-known remarkable case of cocaine-poisoning, where a young woman who was suffering from a tuberculous rectal fistula was given twenty-two grains of cocaine by means of repeated rectal injections in order to produce local anesthesia for an operation which consisted in scraping the anterior wall of the rectum with a sharp spoon. In a quarter of an hour the patient became excited, and began to suffer from clonic spasms in the limbs, opisthotonos, and cyanosis. Death occurred from asphyxia, in spite of tracheotomy and prolonged performance of artificial respiration. At the *post-mortem* examination the blood was found to be fluid, and of a dark brown color, as in cases of poisoning with chlorate of potash. There

were hyperemia of the brain and of the lungs, exudative glomerulo-nephritis, evidently of long standing, together with ulceration of the colon and rectum, reaching down to the submucous tissue. Microscopically there was found albuminoid degeneration of the nerve cells, of the cerebrum, of the heart muscle, of the liver cells, and of the epithelium of the urinary tubules. Dr. Vinogradoff compares this with three other published cases of death from cocaine poisoning, and with cases in which large doses had been given with and without the occurrence of toxic symptoms, and shows that as much as forty-five grains have been borne without any ill effects. The fatal result in the foregoing case, which, it may be remembered, led to the suicide of the distinguished surgeon who operated, is to be ascribed to the increased power of absorption of the ulcerated intestinal wall, and to the retardation of the kidney secretion by the diseased condition of the glomeruli. It would therefore appear that when there is any question of giving large doses of cocaine a careful examination should be made of the condition of the kidneys, and if there is any ground for supposing them to be diseased or functionally inactive, the greatest caution should be employed. It may be remembered that before operating the unfortunate surgeon asked one of his colleagues, who was a professor of therapeutics, what dose of cocaine might safely be given, the answer being, "Not more than two grains." So that the greatest diversity of opinion exists regarding the maximum dose of the drug.—*London Lancet*.

**CURE OF AMENORRHEA: CAUSE OR COINCIDENCE?**—On March 2, 1888, I was consulted by a strong, healthy country girl, aged nineteen, who, however, looked considerably older. I was informed that her menses had stopped at the beginning of December, 1887, and from that time she had been continually laboring under various disorders. She had menstruated for the first time at sixteen years of age; since that time she always enjoyed good health, and worked very hard in the fields. From the age of twelve she had been obliged to work hard to support herself and her mother. The symptoms of which she complained were frequent headache, sometimes with intolerance of light, throbbing in the head, severe pains in the side and back, irregularity of the bowels, derangement of the appetite, and impairment of strength. She informed me that every month a menstrual molen occurred, consisting in reg-

ors, pains in the back and loins, weight at the lower part of the abdomen, lassitude, and dyspnea, but without any discharge. All these symptoms passed away in two or three days, to be succeeded by frequent headache and depression of strength and spirits. After a careful examination in order to exclude pregnancy, I used preparations of iron, iodine, strychnine, bromide of potassium in large doses, purgatives, leeches to the breast and to os timae, stimulants, and hot vaginal injections. None of these remedies, however, afforded any relief to the patient. On January 20th last she fell down from a terrace and knocked her back very badly against the rocks. I was called to attend her, and besides the pain at the back I found that she had a slight discharge from the vagina. I prescribed a liniment to relieve the pain, and ordered perfect rest to the patient. The day after the girl informed me that the menses had returned copiously during the night. Since then menstruation continues regular, and the patient enjoys very good health.—*Dr. J. F. Inglott, British Medical Journal*.

**SECONDARY EFFECTS OF PARENCHYMATOUS INJECTIONS AND EXPERIMENTAL PUNCTURE.** Dr. Decker reports to the *Manchener Medizinische Wochenschrift* the following two interesting cases from his clinic in Wurzburg. A strong girl, of twenty years of age, who had borne six previous parenchymatous injections of mercury well, presented, after another injection of one third of a grain of carbolate of mercury into the nates, marked symptoms of collapse—that is to say, dyspnea, marked cyanosis, edema of the eyelids, small pulse, and vomiting. The same symptoms of collapse appeared in another female patient after an experimental puncture in the hepatic region, and the author believes that the same cause led in both cases to the same result—namely, traumatic excitement and consequent paralysis of the vasomotor nerves, leading to marked abdominal plethora, cerebral anemia, irregular action of the heart, and venous congestion.—*London Lancet*.

**CASE OF CODEINE POISONING.**—While taking temporary charge of the General Dispensary at Birmingham, I called soon after 4 o'clock on the afternoon of August 21st upon a patient in an advanced stage of phthisis. On going up stairs I found him in bed, and he remarked: "I've just drunk a half-quartern of cough mixture. To tell you the truth, doctor, I'm tired of living;

"I'm a burden to myself and my wife." It appears that about ten minutes before my visit he poured out the remnant of his cough linctus into a tumbler and drank it off. The medicine was some that had been left over from a previous attendance at the dispensary. Knowing that a mixture of codeine, of the strength of one grain to the dram, was in common use at that institution to soothe the cough of phthisis, I concluded it would be better at once to empty the stomach. The patient's pulse was 142, small, weak, and compressible; respiration 30, sighing. After drinking several tumblerfuls of warm water, with and without mustard, he vomited freely, and toward the latter part of the process called out he could "taste the cough stuff." I then gave him some whisky, and soon afterward left him with directions that I was to be called in case of certain symptoms arising. On returning a few hours later he was drowsy, but on being disturbed woke up with a violent start. His pupils were small (not pin-point), but, it seems, not smaller than their wont, and they showed no reaction to light. His pulse was 120, full and bounding, a marked contrast from the previous condition, and a red blush was present from elbow to wrist on each arm. He complained of a confused feeling in the head. Tactile sensation seemed perfect all over the body, but he was troubled with an intense itching over the arms and trunk, and to a lesser degree down the legs. While talking to me he was rubbing and scratching himself violently and incessantly. Directions were given to keep him awake for the next five hours, and to administer ten minims of ether every hour, with some black coffee in the intervals. The itching ceased about an hour after my second visit, and the drowsiness passed off at 12:30. He was allowed to fall asleep at 2 P. M.

Next morning the pulse was 108, feeble, and he presented the ordinary symptoms of advanced phthisis. During the day there was a slight recurrence of the itching. On the second day after, I found him eating a chop and feeling better (according to his own account) than he had done for a long time. Since then he has relapsed into a melancholic state.

I ascertained that the linctus contained codeine, and that the patient had not used any for many weeks previously. So far as can be judged, he must have taken about eight grains of the alkaloid. Much of this was probably vomited, as it was swallowed on an empty stomach; but for the same

reason some of it was probably absorbed in the interval of a quarter of an hour that took place before emetics could be brought to work.

The most noteworthy symptoms seem to have been the intense irritation of sensory nerve-endings and altered blood-pressure. Probably many of the manifestations were masked or modified by the advanced phthical condition; but, imperfect as the case may be, the rarity of the occurrence may perhaps warrant this short note.—*Dr. David Walsh, British Medical Journal.*

**PATHOLOGY OF SEVERE BURNS.**—*Dr. Oscar Silbermann, of Breslau*, studying the clinical and pathological signs of the destruction of numerous red-blood corpuscles, found by his experiments: (1) That after extensive burns of the skin the red-blood corpuscles alter their form and lose their power of resistance to heat, drying, compression, and staining. (2) In consequence of these alterations numerous thromboses in the arterioles and capillaries, especially in the finer branches of the pulmonary artery, occur, leading to stasis in different organs—for example, lungs, kidneys, stomach, bowels, liver, spleen, skin, and brain. (3) The large deviation of the pulmonary capillary circulation produces a considerable impediment to the emptying of the right heart and serious venous congestion, as well as dangerous arterial anemia. (4) This state, coupled with the above-mentioned symptoms, leads to bleeding and parenchymatous alterations in the affected organs. (5) The interference with the circulation also produces dyspnea, a small pulse, angina, eclampsia, and anuria, as well as a remarkably low temperature.—*London Lancet.*

**DERMATITIS PAPILLARIS.**—At the annual meeting of the Massachusetts State Medical Society, *Dr. L. Heitzmann, of New York*, read a paper on this subject. He said in substance: Benign tumors will not recur after extirpation; but there are many cases where tumors which are proven both clinically and microscopically to be non-malignant, begin to recur after their removal, sometimes assuming a larger size than the original. Such tumors are known to the surgeon as recurrent fibroids. A simple fibroma may gradually change into sarcoma during the course of a series of operations for its removal. Sometimes the growths commonly called "moles" after their removal will recur in the shape of scars, which are generally called spurious keloid. In a

patient of Dr. Nicolai the application of green soap caused the growth of large, branching hard scars over the chest. On some people every wound of the skin will be followed by such a growth. Such a condition may follow an eruption of acne pustules, and these growths have been termed by Kaposi dermatitis papillaris.

A negro who slept on a pillow filled with horse-hair developed such growths upon the neck and occiput. In another case, that of a Hebrew gentleman, constant picking of a few acne pustules was the starting point of the disease. Kaposi considers the disease a primary one, but the author thought it secondary to the irritation, arising either from an acne or from a sycosis. This view agrees with the opinion of Hebra, who called it sycosis frambesiiformis.

What the cause is we do not know. Von Recklinghausen thought it followed the distribution of the nerves. In the experience of the reader this had not been true. It seems to depend on a peculiar activity of the skin which enables it to respond to moderate irritation. It is most common in negroes, in whom pricking of the lobes of the ear may be followed by such a growth. The Hebrew race is also prone to the formation of this recurrent fibroma. It is composed of interlacing bundles of fibrous tissue, with a large amount of protoplasm or medullary corpuscles between the bundles. Sometimes the latter become so great that it is called myxo-fibroma. The larger the amount of this free substance the more rapid the growth of the tumor. We also meet with indifferent corpuscles or medullary corpuscles, which point to rapid growth of tissue.

From a pathological standpoint the recurrent fibromata are allied to keloid and dermatitis papillaris. The papillary character is of secondary importance, depending on the regular distribution of the blood-vessels in the superficial layers of the cutis. Treatment is tedious. Caustics, cutting, and the hot iron are forbidden; they will aggravate the disease. Nitric acid may be applied cautiously. The history of one case, in whom operation was done in Vienna, was related, in whom the result was a great increase in the size and number of growths. A three-per-cent solution of salicylic acid seems to promise as well as any thing.

**THE CLINICAL SIGNIFICANCE OF ALBUMINURIA.**—The importance of a proper interpretation of albumen in the urine, not only for purposes of medical prognosis, but especially in connection with the acceptance

of life insurance risks, appeals strongly to every member of the profession. The almost universal usage of insurance examiners is, we believe, to reject albuminuric subjects, or, at least, to defer their acceptance till repeated subsequent examinations have proved the absence of the offending substance.

Yet cases are accumulating in which it is claimed recovery has ensued after a temporary or periodical occurrence of albuminuria. Many such instances are collected in the extended monograph of the late Prof. Calvin Ellis, which formed the last of his valuable clinical and pathological studies.\* Our English brethren, in their annual meeting at Leeds, have been considering the same subject, and their deliberations, albeit involving, perhaps, a "conclusion in which nothing is concluded," will have an interest for our readers.

Dr. F. W. Pavy, whose views of "cyclical albuminuria" are sufficiently well known to the profession, opened the discussion, and, as might be expected, took the ground that albuminuria *per se* in a patient presenting, after careful examination of all his organs and functions, no other aberration than the albuminous urine, need not necessarily militate against the safety of the insurance risk. He classified the cases under three heads: (1) Those in which very small traces only are observed; (2) those in which there is a notable quantity of albumen, and that constantly; (3) cases of the so-called cyclical variety, where there is regularly a notable amount at one period of the day, and an absence at other periods. The first group he considered the most favorable as to prognosis, the second least so, and the third of intermediate augury. Even in the second, he thinks that some cases run on without serious results arising, but admits that our knowledge does not at present permit us to differentiate such from cases of Bright's disease. Of cyclical cases he thinks a favorable opinion may be given as a simple medical prognosis, but, where the question of life-insurance is involved, suggests that an increased premium be required.

Dr. George Johnson, of the King's College Hospital, took a square issue with Dr. Pavy, and repudiated all "physiological" or "functional" albuminuria. Admitting that an albuminuric subject might have no symptoms, and might thus fall into Dr. Pavy's favorable classification, he claimed that such was merely a parallel case to that of a patient with cardiac valvular incompetence, who

\*The Significance of Albuminuria. By Calvin Ellis, M. D. 1880.

may live for years without any symptoms, but whose disease is not to be therefore diagnosed as functional. The fact of the recently ascertained frequency of albuminuria he interpreted, not to show its lack of gravity, but only to indicate the necessity for universal urine testing.

Dr. Maguire said he had found disorder of the circulation in all cases of functional albuminuria. The disorder was in the direction either of increased or lowered arterial tension. The former occurred in persons having a family history of Bright's disease; the latter in persons of weak circulation, in whom the albuminuria was essentially cyclical, though the latter peculiarity might occur in Bright's disease also.

Dr. Pye-Smith believed that there was no physiological albumen, and that functional albuminuria was for the time being pathological. He compared albuminuria with hemoptysis, always serious but not necessarily indicating incurable organic disease. He would defer an insurance of the albuminuric subject rather than try to draw a distinction which was often impossible to be drawn.

Prof. W. T. Gairdner, of Glasgow, said that the occurrence of albumen after great physical or mental strain showed, not that the albuminuria was physiological, but that the strain—whether, for instance, in pedestrianism or in cramming—was unphysiological. He would, on the other hand, admit the term *functional* albuminuria. Its presence in a life-insurance applicant calls for postponement.

Dr. Rabagliati interpreted albumen in the light of the specific gravity. If the latter was above 1.020, it suggested beginning lithemic nephritis. If below 1.010, it meant further advance of the disease. The Scottish Widows' Fund found the average death-age of albuminurics to be fifty-seven, and he advised considering that to be the life expectation of an albuminuric without casts or other definite lesion.

Dr. Saundby would accept for insurance "unquestionably" a case where the albumen disappeared after a period of recumbency. He would always object a risk where there had been previous nephritis, and said that while he believed there were other innocuous forms of albuminuria, they were, for insurance purposes at present, speculative, and should be taken only for short periods or increased premiums.

Dr. W. J. Tyson thought the number of deaths from Bright's disease was small, compared with the number of cases of albumin-

uria met with in practice. He lamented the popular knowledge of the usual significance of albumen, which gave patients much unnecessary anxiety and distress.

Dr. George Harley believed that the albuminuria of hepatic, cardiac, cerebral, and pulmonary origin was associated with a specific gravity of over 1.015, and was thus distinguishable from the albuminuria of Bright's disease, which, being associated with disorganization of renal tissue and retention of salts, always had a lower density of the urine.

In general, the position that albuminuria is not necessarily of grave import seemed to be taken by Drs. Pavy, Tyson, Saundby, and measurably by Dr. Drysdale; Drs. W. T. Gairdner and Eddison occupying a somewhat intermediate position, both said they looked upon albumen as a "danger signal." The more conservative view, which distrusts all cases that have been albuminuric, was held with more or less rigidity by most of the other speakers.

The physician who looks to the Leeds discussion to clear up the question of the prognosis of albuminuria will be much disappointed. The solution of the problem requires the answer to two questions. First, is albuminuria consistent with health? Second, if so, do we possess any means of distinguishing such cases from those in which it accompanies grave disease? The answer to the first question, which a decade of years ago would have been universally negative, is now given by an influential contingent of the profession as affirmative. The answer to the second question is not yet forthcoming.—*Boston Medical and Surgical Journal*.

#### LAPAROTOMY FOR HYDATID OF THE LIVER.

In an elaborate paper on the treatment of echinococcus cysts, Dr. Davies Thomas says that it is not possible to estimate the value of tapping, parasiticide injections, and electrolysis, because the cure which often appears to follow is illusory. He sees reason to believe that tapping operations fail to cure in fully 40 per cent, and probably in a larger proportion. Taking aspiratory punctures and ordinary tapping operations together, the deaths amounted to nearly 18 per cent; but the mortality following aspiratory puncture, whether single or multiple, was only about half that of punctures with an ordinary fine trocar. Dr. Thomas believes that the greater the number of punctures required the smaller the probability of cure, and points out that though simple puncture is generally devoid of risk, it has

been known to cause sudden death, sometimes apparently from shock. Sometimes, however, in the case of pulmonary hydatids, from suffocation by the fluid contents of the bladder-worm. The objection to puncture as the mode of treatment for internal hydatids, however, lies less in the occasional perils of the operation than in its frequent inefficacy.

Dr. Thomas considers that nothing can be said in favor of parasiticide injections into the sac and the employment of electrolysis that does not apply with equal force to simple puncture; and, moreover, each possesses drawbacks of its own. The statistics of abdominal section for hydatid of the liver compiled by Dr. Thomas are extraordinarily good. He has collected sixty-eight cases thus treated with only seven deaths; in one of these seven cases the patient died suddenly during the operation from sudden arrest of the heart, due to a hydatid cyst in it; in two others there were multiple hydatids in the body. Even including these three cases, the recoveries amounted to within a fraction of 90 per cent. The method by two stages, producing peritoneal adhesion by incision and packing with carbolyzed gauze (Volkman's method), showed a mortality of a fraction over 19 per cent; the operation by caustics gave a mortality of 33.68 per cent, while that by the *canule à demeure* was 26.66. The cases treated by Volkman's method only numbered twenty-one, but even so the statistical evidence appears to be strongly in favor of abdominal section as the safer procedure. Where unruptured cysts present on the convexity of the liver, the treatment offers greater difficulty, for Dr. Thomas states that thoracic incisions show a high rate of mortality. As to pulmonary hydatids, however, the risks and disadvantages of puncture are so great and the results of radical operations on the whole so favorable that Dr. Thomas considers that there ought to be but little difficulty in making a choice of treatment in ordinary cases. Where a hydatid, whether of the liver or of the lung, has ruptured into the pleura, free incision into the pleura appears to be the only treatment which holds out a fair promise of success.—*British Medical Journal*.

**FATAL HEMORRHAGE FROM THE STUMP OF THE UMBILICAL CORD.**—Uncontrollable hemorrhage on separation of the cord in the new-born infant is not common. It is very serious; only 32 per cent of recorded cases appear to have recovered. Dr. Tross, of Karlsruhe, describes a case in the Berlin

*Klin. Wochenschrift*. The infant was five days old, as the stump of the cord was in process of separation, severe hemorrhage set in. A single vessel was found to be the source of the bleeding, but all attempts to tie it so early failed. The umbilical tissues were secured by transfixion, but free hemorrhage took place from the tracks made by the transfixing needle. The tissues were firmly tied above the seat of transfixion, and the hemorrhage at last ceased. The stump was swabbed with perchloride of iron and wool containing tannic salt laid upon it, and retained by means of a binder. In the night hemorrhage recurred; the mother, acting on Dr. Tross's advice, at once tied another ligature round the parts below that which he had applied, but in vain—the child died. The entire integuments assumed, after death, a remarkable lemon yellow tint, which steadily increased. The blood which escaped during life showed no disposition to coagulate. The above is described by Dr. Tross as a case of omphalorrhagia hæmatorum spontanea.—*Ibid*.

**IS LEPROSY HEREDITARY?**—Ortmann, in the *Archiv f. Derm. and Syph.*, Heft iii, 1889, gives a concise abstract of a paper by Dr. Armauer Hansen, in which the author gives the result of an interesting investigation. He went to America to visit the lepers who had emigrated from Norway, and examined, in the States of Wisconsin, Minnesota, and Dakota, lepers who had originally left Norway, and their descendants born in America. He arrived at the interesting result that of 160 lepers who had emigrated to America the offspring had remained free to the third generation. This result, the author believes, shows emphatically that leprosy is not a hereditary disease. The fact that, of the 160 emigrants, only 16 or 17 are still alive without any new case having sprung up does not, in his view, show that leprosy is not contagious. He considers that the different mode of life in the new country does not afford the same opportunity of contagion that is given by the peculiar conditions of life in Norway.—*Ibid*.

**ACETANILIDE IN CONVULSIONS.**—In acetanilide I am sure we have a most valuable remedy for the relief and prevention of convulsions. Clinical experience for one year justifies the conclusion. The action of the drug is rapid, usually beginning to manifest itself within an hour and not infrequently within twenty minutes. Its full effect was reached in four hours.—*Dr. I. N. Love, Med. Age*.

# The American Practitioner and News

"NEC TENUI PENNÂ."

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H. A. COTTELL, M. D., } - - - Editors.

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## WILL PHTHISIS EVER BE STAMPED OUT?

The British Medical Journal, October 12th, contains two pictures and a favorable notice of a pocket spittoon, whereby a lover of his race, Dr. Dettweiler, of Frankenstein, hopes to materially lessen the spread of phthisis. "The small apparatus is constructed on the principle of the safe ink-bottle, and is furnished with a closely fitting spring lid at one end, and a screw-off mount for emptying at the other. Its contents may be disinfected by a solution of perchloride of mercury (1 to 200)." The flask may be conveniently carried in the pocket.

It is to be hoped that these flasks will be imitated in, or imported into, this country, and that every doctor will make it his business to see if the average American victim of phthisis can be made to show himself to be more than an average philanthropist by using the device, and thus relinquishing the right of an American citizen to spit when and where he pleases.

Whatever bearing the discovery and subsequent study of the bacillus tuberculosis may have upon the therapeutic management of phthisis, the hygienic view of the subject, though somewhat utopian, is simply sublime. It contemplates nothing less than the banishment of the disease from among men.

In the spread of phthisis the two factors of

hereditary predisposition and direct infection by means of the specific bacillus are admitted by all phthisiologists. The elimination of the former, under the law of the survival of the fittest, might in the lapse of cycles take place in the case of man, as it has taken place in the case of the rat in the lapse of centuries; but in the present state of the social order no such consummation need be looked for. The subjects of tuberculosis, be the disease latent or active, will still marry and be given in marriage, with the inevitable fatal results to their offspring.

The elimination of the second factor is simple and beautiful in theory. It is admitted on all hands that the bacillus is now transmitted from person to person through the medium of dried sputum in the dust of houses and streets, and by the milk and flesh of infected animals. Boiling all milk (how about butter?) used in the household and cooking thoroughly all meats seal up the latter source of infection, while nothing is simpler than the collection of the sputum of phthisical patients in proper receptacles where it can be submitted to heat or powerful chemicals and be thus destroyed.

Good work in this direction is certainly being done, and a shrinkage of the death-rate from phthisis may be confidently expected if the profession will do its duty in every case. But when we consider the present ubiquity of the germ, the ignorance of the average victim of the disease, and the indifference of the world at large to special hygienic precautions, it looks as if the hygienist's hope were not likely to find fruition until after the millennium.

The Canada thistle is not as widely disseminated to-day as is the tubercle bacillus. The thistle might be stamped out of existence if everybody interested in its destruction would dig it out of his own field or garden, or the highways, before seeding-time. But, however careful to destroy it the ideal agriculturist may be, there will be a sufficient number of bad farmers and gardeners to conserve the thistle, which will continue to flourish to the end of time. As the world goes, men are more careful of their property than of their health. Can we expect them to do more for the destruction of the weeds of disease than they are willing to do for the destruction of the weeds of the field?

## Notes and Queries.

**CINCINNATI LETTER.**—The Southwestern Ohio Medical Society held its first semi-annual session at the Burnet House, Cincinnati, October 9th and 10th, with the president, Dr. W. A. Campbell, of Eaton, in the chair.

Dr. C. G. Comegys, of Cincinnati, made the address of welcome, and W. A. Campbell, of Eaton, made the presidential address, in which he spoke of the hopes and desires of the Society and the good it might accomplish.

Dr. J. C. Culbertson, of Cincinnati, delivered an address on the importance of medical societies and organizations, and the necessity of doctors taking a part in the affairs of State.

Dr. George Goodhue, of Dayton, read a paper on Rhinoplasty, which was discussed by Drs. Connor and Ricketts.

Dr. George W. Ryan, of Cincinnati, read on Congenital Luxation of Both Hip Joints; discussed by Dr. C. Seth Evans, of Cincinnati.

Dr. A. B. Thrasher, of Cincinnati, reported the removal of a cocklebur from the throat of a fifteen-year-old girl, where it had remained for five days. The removal was effected by Mackenzie's laryngeal forceps.

Dr. H. L. Taylor read on Hemorrhoids and Fistula, which was discussed by Dr. W. W. Dawson.

Dr. B. M. Ricketts, of Cincinnati, read on the subject, Ounce Doses of Iodide of Potassium in Syphilis.

Dr. Goodhue reported the case of a young lady who took 1,200 grains a day for seven weeks, and was cured.

Dr. C. H. von Klein, of Dayton, read on the subject, Hypertrophy, Atrophy, and Deviation of the Nasal Septum, which was discussed by Dr. A. B. Thrasher, of Cincinnati.

Dr. Charles W. Dodd, of Cincinnati, read a paper on the Relation of Ocular to General Diseases.

Dr. F. Forchheimer read a report, and presented a new instrument—hematometer—for determining the amount of hemoglobin. He said this instrument was the only means of determining the difference between anemia and chlorosis.

Dr. A. D. Murphy, of Pleasant Plain, read

a paper on Digitalis in Acute Pneumonitis in Children and Infants. The paper was discussed by Dr. Goodhue, who favored stimulating treatment in the last stages of pneumonia.

Dr. A. W. Ashburn, of Batavia, read a paper on The Therapeutics of Antipyrine. He estimated the drug and its uses very highly, and condemned its indiscriminate use by the laity.

Dr. E. W. Mitchell, of Cincinnati, agreed with the essayist in his high opinion of antipyrine, and thought it a very safe antipyretic. In anemic and neurotic men he found the drug had a bad effect.

Dr. A. M. Brown, of Cincinnati, had used the drug in all diseases of nervous origin and in diabetes. He thought the drug did not receive the condemnation it deserved. It was whispered about among the doctors that the high mortality of the last typhoid-fever epidemic in Cincinnati was due to the use of anti-pyrine.

Dr. W. S. Christopher spoke in a scientific manner on the subject of Digestion.

Dr. R. T. Trimble, of New Vienna, read a paper on Puerperal Eclampsia.

Dr. A. C. Hawley, of Eaton, read a paper on Abortions, and the subject of the treatment of abortions was discussed by Dr. Gustave Zinke, of Cincinnati.

Dr. C. A. L. Reed read a paper on A Case of Ovariectomy with Complications.

Dr. R. B. Hall read on Abdominal Section, Cases and Remarks. He indorsed early operations, as thereby malignant growth was often prevented, and its recurrence made less liable. Dr. Edwin Ricketts urged early interference.

Dr. W. W. Hall, of Springfield, reported a case of sarcoma of the pelvis. The paper was discussed by Drs. Longstreet, Taylor, Seth Evans, and Rufus B. Hall.

The subject of diphtheria, which is just at present keeping the Cincinnati doctors from having nothing to do, was fully discussed. Dr. J. T. Whittaker, of Cincinnati, exhibited some diphtheria bacilli under the microscope. He discussed the etiology of the disease. Dr. Joseph Eichberg, of Cincinnati, discussed the pathology. Dr. Wm. Carson, of Cincinnati, discussed the identity of croup and diphtheria. Dr. Dan Milliken, of Hamilton, discussed diphtheria of the genitals. Dr. Dandridge, of

Cincinnati, spoke of tracheotomy. Dr. William Johnson, of Cincinnati, discussed intubation; Dr. C. S. Caldwell, of Cincinnati, post-diphtheritic paralysis. Dr. P. S. Connor, of Cincinnati, was not partial to tracheotomy in diphtheria.

At the recent contest for the positions of *externes* at the Cincinnati Hospital, becoming *internes* after a period of six months' service, there were fourteen candidates, eight from the Medical College of Ohio and six from the Miami Medical College. Messrs. Landis, Mussey, Freiburg, Bettman, Brady, and Morris were the successful candidates from the Ohio College, and Mr. Morrison from the Miami Medical College.

The Archives of Pediatrics is publishing a series of articles from the gifted pen of our fellow-townsmen, Dr. F. Forchheimer, on the subject of Diseases of the Mouth (non-surgical). This series is being read with interest by the many subscribers of that journal.

The Universal Annual of the Medical Sciences contains writings from Drs. P. S. Connor, J. T. Whittaker, H. A. Smith, M. H. Fletcher, E. S. McKee, W. H. Wilder, and H. L. Taylor, of Cincinnati. Some of these are among the most valuable of the many choice articles in that work.

The Daily Commercial-Gazette, of this city, found so much news in a recent Cincinnati correspondence in a medical journal that it published almost the whole correspondence.

The new amphitheater at the Cincinnati Hospital, which is to seat eight hundred students, is completed and ready for use. It is quite an addition to the teaching facilities of the city.

Dr. H. Longstreet Taylor has succeeded Dr. A. B. Thrasher as editor of the Cincinnati Medical Journal. Dr. Thrasher, who has been editor of the Journal since its foundation, four years ago, has found other duties very urgent, and was compelled to relinquish some part of his labors.

Dr. W. W. Dawson, last ex-president of the American Medical Association, has been made consulting surgeon to the Cincinnati Hospital.

Dr. J. C. McMechan has long been known as one of the most amiable of the profession in

Cincinnati, and his many friends will not be surprised to learn that in his ever-readiness to be of service to his friends he has severely injured the muscle of accommodation.

E. S. M'KEE, M. D.

PREVENTION OF DIPHTHERIA.—The State Board of Health has issued the following circular:

OFFICE OF THE STATE BOARD OF HEALTH,  
BOWLING GREEN, KY., October 17, 1889. }

*To the Health Officials and People of Kentucky:*

The unusual prevalence of diphtheria in many sections of the State makes it important that the attention of our health officials and people should be called to the best known methods for preventing the occurrence or restricting the spread of the disease.

Diphtheria is both contagious and infectious, attacking persons of all ages, but affecting children much more frequently than adults. It may be communicated from the sick to the well directly, or by means of persons, clothing, toys, pet animals, or other things infected by the sick or sick-room, and especially by cups or other articles which pass from mouth to mouth. In a sense it is a "filth disease," sometimes seeming to originate spontaneously in the presence of bad sanitary surroundings, and certainly spreading more rapidly and being most fatal in such localities.

Diphtheria is a preventable disease. Proper preventive measures are almost invariably followed by the limitation of the disease to the first case or cases. When it gets away from the primary cases and makes its escape upon the community, somebody is to blame. The sooner we accept this as a sanitary maxim the sooner we shall begin to do our duties as individuals and as communities.

As soon as it is known that a person has diphtheria he should immediately be separated from the rest of the family, and put into a sunny, well ventilated, and plainly furnished room, preferably on the upper floor, and as disconnected as possible from other rooms, especially the living and sleeping rooms of children. No other person

besides the nurse and necessary attendants should be permitted to enter the room, and they should take every precaution not to carry the infection to others.

The health officer of the town or county should be notified within twenty-four hours, and he should co-operate with the physician and family to keep the disease from spreading. A blue flag, or a card, with diphtheria on it, in large, plain letters, should be placed in a conspicuous position on the house. No child or person having the care of children should be permitted to enter the house.

The discharges from the throat, mouth, and nose are exceedingly poisonous, and should be received on soft cloths and immediately burned or immersed in a solution of chloride of lime, six ounces to the gallon of water. The bed and body-linen, immediately upon removal, should be boiled for half an hour, or immersed in the chloride of lime solution for twenty-four hours. In no case should such clothing go into the family wash.

No person from a house where there is diphtheria should go into public assemblies, as churches, fairs, or concerts, and especially schools.

Persons who have had diphtheria should not mingle with the public for some time after the last trace of the disease has left the throat and nose, and only after all their clothing has been thoroughly washed or disinfected. No child from a house where the disease has prevailed should be permitted to enter school except upon the certificate of a physician that it is safe to do so.

In case of death the body should be wrapped in a sheet saturated with the chloride of lime solution, and put in a tight coffin. The funeral should be strictly private, and in no case should children or those having the care of children be permitted to attend.

After death or complete recovery the room should be disinfected under the supervision of the health officer or a competent physician. First, mattresses, comforts, and other like things badly soiled should be

burned. Such clothing and bedding as can be washed should be boiled or placed in the chloride solution as above directed. To disinfect the room proceed as follows: Arrange the contents of the room so as to expose the greatest amount of surface to the action of the disinfectant. Close the apartment as completely as possible, stopping all openings, as chimney flues, key holes, etc., through which the gas might escape. Thoroughly dampen the floor, walls, and furniture. For a room ten feet square use three pounds of sulphur, moistened with alcohol, in an iron pan, placed in a tub containing a few inches of water, to avoid danger from fire. When certain the sulphur is burning well, leave the room, close the door and allow the room to remain tightly closed for ten or twelve hours. Afterward the room should be thoroughly ventilated for several hours, and then the floor, and ledges over windows and doors, and other places likely to retain dust should be washed with the chloride solution and then with soap and hot water. The house and premises generally should be put in the cleanest and best condition possible.

To be effectual the precautions here suggested should be rigidly observed. Imperfect isolation and disinfection are worse than useless, giving rise only to a false sense of security.

County and municipal boards of health have full authority under our laws to enforce these rules, and will fall short of their duty if they fail to do so.

PINCKNEY THOMPSON, M. D.,

*President*

J. N. M'CORMACK, M. D.,

*Secretary*

**FRUIT GATHERING AND THE SPREAD OF INFECTION.**—We have frequently had occasion to criticise the imperfections of those sections of the Public Health Act, 1875, which relate to infectious diseases. Those clauses were framed with the object of preventing the spread of infection; but cases are constantly arising in which flagrant disregard on the part of individuals of the safety of the community at large pass un-

punished, owing to the narrowness of the statutory provisions or to some legal quibble as to the exact meaning of particular words or phrases. An instructive case in point came before the magistrates of the Malling Petty Sessions on September 9th. The proceedings in question were taken at the instance of the Maidstone Rural Sanitary Authority against a local fruit-grower for allowing his red currants to be picked in his orchard by children who were still in the desquamating stage of scarlet fever, and for sending the fruit so gathered to a London market. The proceedings were taken under section 126 of the Public Health Act, which provides that "any person who . . . gives, lends, sells, transmits, or exposes, without previous disinfection, any bedding, clothing, rags, or other things which have been exposed to infection from any such disorder" (that is to say, "any dangerous infectious disorder") "shall be liable to a penalty not exceeding five pounds." But unfortunately the magistrates dismissed the case, on the ground that "fruit" could not be regarded as coming within the meaning of the term "other things," as it is not a "thing" *ejusdem generis* with the articles which are definitely specified in the section. This decision may or may not be good law, but as the point is a matter of considerable importance it would be well if the decision of a higher court could be obtained upon it. If the decision is right, it is to be hoped that the law will soon be so amended and strengthened as to enable such cases as that to which we have called attention to be properly dealt with. In the mean time there is a distinct public danger in the handling of fruit or other food by persons who are in a condition to transmit infection, and every available precautionary measure should be adopted.—*British Medical Journal*.

THE OPEN DOOR OF QUACKERY.—In the North American Review for October, Drs. William S. Eggleston, Austin Flint, and R. Ogden Doremus discuss the question of quackery in the United States. Of the three papers, Dr. Eggleston's is by far the best,

since he attacks the question in an open, honest way, and shows the faults and obstacles to improvement. The other two writers seem more to deal in excuses and apologies for the schools they represent, and think that the condition of things in our country in respect to quackery might be worse. Dr. Eggleston gives some pregnant facts, true and startling.

Ours is the only country in which fraudulent medical colleges have existed or do exist. It is the only country in which the government has no control over the medical schools and medical education. Of the total number of medical schools started in this country, 222, 105 are extant, and 117 exist. That is, almost as many are dead as alive. There are enough medical colleges in the United States to furnish medical attendance for 300,000,000 people.

The State boards, as a whole, advocate improved preliminary education and suggest that schools be modeled more on the plan of the foreign schools—a thing which individual schools naturally object to.

While Dr. Eggleston shows the state of affairs exactly as they exist, the other two writers feebly add that we have some men well prepared when they begin the study of medicine, and some schools require a long graded course.

It is noticeable that men connected with medical schools in this country are never very sanguine about raising the standard of medical education, especially when it tends to decrease the number of their students, and consequently their incomes. A principle is a very good thing until it costs something, and then it loses its attraction.

The idea that this is a free country is never lost sight of, although we do not agree as to the meaning of the word "free." Any ten or twelve men with sufficient influence (or money, which is the same thing) are free to obtain by money or otherwise a charter from their respective legislatures to found a medical school.

Our country has always opened its doors to all classes, and quacks have not failed to enter. Now, some States are doing good work

in driving out quacks, but most States are indifferent. Maryland has a law, but on account of the general indifference of those interested it amounts to nothing. Baltimore holds its doors open for quacks, and they enter, as every one knows, because every one is apathetic and indifferent.—*Maryland Medical Journal*.

**THE PROPHYLAXIS OF TUBERCULOSIS IN BAVARIA.**—At the instance of the Barvaian Home Office, the Ober-Medicinal Ausschuss (Superior Medical Committee), with Prof. Bollinger as its reporter, has just pronounced on the theory of Dr. Cornet, of Berlin, as to the spread of tuberculosis, and the best means of checking it. To Dr. Cornet's method and findings it has no exception to take, indicating as they do the danger proceeding from the pulverized sputum of the phthisical, a danger recognized by the profession ever since the discovery of the tubercle bacillus. What the committee objects to in Dr. Cornet's view is his entirely ignoring the influence of heredity and predisposition as factors in producing or inducing the disease. He goes so far as to stigmatize with the epithet "*unselige*" (fatal) the doctrine (practically and theoretically well founded) of an innate and inherited tendency to tuberculosis. The committee, in answer to the Home Minister's question, whether Dr. Cornet's results would warrant him in accepting these as the basis of practical measures for arresting the diffusion of the malady, remarks that Dr. Cornet's deduction involves an extremely optimistic standpoint, and that it can not assent to his dictum that "the prophylaxis of tuberculosis attains its end with the simplest means imaginable." Measures of State for the prevention of the disease must await the solution of the problem whether in the genesis of tuberculosis contagious infection or inherited tendency plays the chief part. Dr. Bollinger, before an audience of the first Upper Bavarian Medical Diet, recently proposed that the State prisons, in which the mortality from tuberculosis averages from thirty-eight to sixty per cent, should be utilized for the ex-

perimental determination of the difficulty. With this view a prison should be repeatedly cleansed and disinfected as if it harbored the plague or smallpox. Every case, moreover, of tuberculosis occurring in it should be isolated, or, better still, cleared out. The reduction, or disappearance in these circumstances of the tuberculous cases would prove that infection proceeding from the phthisical or from the infected locality played the chief part, and that inherited tendency was the less important factor. The committee concludes that the Home Office should institute the investigation thus recommended, and, considering the importance of the matter, should provide the necessary grant without delay. Meanwhile, our readers may be reminded that Dr. Cornet, with a dust suspected to be tuberculous, obtained by scrubbing a wall of from one to two square meters with a sterilized sponge, infected 392 porpoises, and that of these 196 shortly thereafter died under acute septic and purulent attacks, while the survivors remained partly unaffected, partly tuberculous—the latter dying in from thirty eight to fifty days after infection. The whole subject, indeed, is agitating the profession in Bavaria to its depths, and the medical societies, which meet during the second half of October, have received from the Home Office a mandate to discuss the criticism passed by the Upper Medical Committee on the practical application of Dr. Cornet's views.

**THE NEW PHARMACOPEIA GERMANICA.**—Next month (October) the Reichs-Pharmacopöe Commission (Imperial Pharmacopoeia Commission) meets in Berlin to frame a new (that is, the third) edition of the *Pharmacopoeia Germanica*, so as to have the work completed for 1890. The scientific discoveries or inventions, and the practical experiences made known in materia medica since the publication of the second edition, will in this forthcoming one be incorporated and rendered available. At the same time it will not undertake, any more than its predecessors, to set for it all those remedial

agents which individual German physicians have prescribed and apothecaries have made up. In the preparation of these remedies the most diverse rules and prescriptions have been followed, resulting in inconveniences and errors, sometimes serious to the public and compromising to the profession. To obviate or minimize this confusion, the German Apotheker-Verein (Society of Apothecaries) has resolved to issue a supplement (*Ergänzungsbuch*) to the forthcoming Pharmacopeia, which shall deal with all the remedies not given in the official dispensatories, and put the prescriber *au courant* with the latest and most accredited additions to his resources, both as to chemical quality and preparation. The profits accruing to the society from the sale of this supplement will, it announces, be devoted to a philanthropic purpose.—*Lancet*.

CONTINENTAL INTEMPERANCE.—The Belgian Patriotic League against alcoholism is about to issue a new illustrated monthly journal in Flemish. The official journal of this active association gives a serious epitome of disastrous results arising from the expenditure in one year in Belgium of 125,000,000 francs on alcoholic beverages, among which 70,000,000 liters of gin were consumed. Among these consequences are eighty per cent of hospital inmates from drinking, with prisons, asylums, and mendicity depots filled with the drunken. Since 1872, taking into account the increased population, insanity has augmented 45 per cent, crime 74 per cent, suicides 80 per cent, mendicity and vagabondage 150 per cent. In Germany 406,000,000 of marks were spent on alcohol during the twelve months, just 24,000,000 less than on the war budget. In that country nearly one third of the sick, one half of the poor, and 70 per cent of criminals are incorrigible drinkers.

TUBERCULOUS MILK.—At the first general meeting of the South Durham and North Yorkshire Veterinary Medical Association, held at Darlington on the 18th inst., an ad-

dress was delivered by the president, Mr. Nettleton, of Northallerton. In the course of his remarks he referred to the transmission of diseases from animals to man, and especially dealt with the subject of tuberculosis, which he said was a source of contamination of milk; and he remarked that the number of diseased cows in England at the present time was enormous, and yet, as long as they could walk and the mammary glands secrete, the milk was used for human consumption. It had been demonstrated that calves dying from acute diarrhea when a few months old, having been born of healthy parents but suckled by a tuberculous cow, owed their death to tuberculosis. He believed there would be less human phthisis were measures taken to stamp out the disease. Another feature he pointed out is that the cream is always richer in the milk from a tuberculous cow—a "richness" which, he suggested, might be due to the admixture of pus with the secretion. (!) The disease is more common in Alderneys and Guernseys; he had never met with it among black cattle.—*London Lancet*.

PEPTIC ESSENCE COMPOUND.—Messrs. Arthur Peter & Co., of this city, have recently prepared a digestive compound of unusual strength and of most palatable qualities. Its essentials are pepsin, pancreatin, diastase, and lactic and hydrochloric acids, combined with glycerine and aromatics. An ounce of the new compound will digest three thousand grains of coagulated albumen—an exhibition of unusual peptic power. It is certainly worthy of a trial at the hands of the profession. (See advertisement in this issue.)

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#### SPECIAL NOTICE.

G. W. WATTS, M. D., Auxvasse, Mo., says: I find Celerina very useful in cases of old persons whose digestive powers are failing, and in the convalescing period of those old persons from acute diseases, such as pneumonia, bronchitis, gastro-enteric troubles, etc. In two cases recently treated of this kind Celerina seemed to restore both the nervous and digestive systems. Both of these cases were very old persons; they are now apparently well.

# THE AMERICAN PRACTITIONER AND NEWS

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*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we would downright facts at present more than any thing else. — RUSKIN.*

## Original Articles.

### TREATMENT OF ERYSIPELAS.\*

BY AP MORGAN CARTLEDGE, M. D.

*Demonstrator of Anatomy, Kentucky School of Medicine.*

Thanks to antiseptic surgery, we of to-day do not have to combat surgical erysipelas as did our forefathers in medicine; yet I take it the time will never be when this poison is entirely eliminated from accidental injuries, many of which, because of a trivial nature, are not treated by a physician from the outset; then there are cases the result of carelessness on the part of the physician. We should not be too quick to censure the physician, however, for a knowledge of the facts may exonerate him from all blame. In private practice it is not easy or possible to control all the patients of this kind which fall to the physician's lot.

In considering the subject of erysipelas, I think best to do away with the old distinction of idiopathic and traumatic, believing that the affection is always essentially traumatic, viz., requiring for its successful inoculation on the human subject a breach of tissue involving the epidermis alone, or epidermis and deeper structures.

That the susceptibility of the individual to the growth and propagation of the specific microbe may be greatly increased by certain morbid conditions of the blood and viscera, there seems to be abundant evidence. This explains the frequency with

which some persons are attacked with so-called idiopathic erysipelas of the face. It also explains the prevalent supposition among both laity and doctors that one attack of erysipelas predisposes to another. Notable among the visceral lesions which render the individual more susceptible to this disease may be mentioned chronic nephritis and diabetes. I think I have observed a special marked disposition on the part of those addicted to the use of alcoholic beverages. It is easy to see how any cause which interferes with elimination would act in a general way as a predisposing cause. The most important point in the pathogenesis, as well as the etiology, for us to remember is, that erysipelas is pre-eminently a local disease primarily; that it is, as is proven conclusively by Fehleisen and others, due to the introduction of a specific microbe upon an abraded or wounded surface, and that, the conditions being favorable, its growth and propagation are a natural sequence. Given this light to guide us, we easily explain the numerous errors which have been recorded from time to time in the books regarding the development history of the disease. We now know that it is absurd to suppose one tissue of the body more prone to erysipelas than another. Scalp wounds, so long thought to be the especial victims of this unwelcome visitor, are now treated in a way which disdains entertainment. Though young in the profession, I well remember when I cherished that beautiful theory of the peculiar anatomical disposition of the head circulation as explaining the great frequency of erysipelas in wounds of this region.

The true cause (like truth often is elsewhere) was on the surface, while philoso-

\* Read before the Louisville Surgical Society, September 16, 1889.

phers expended their energy and brilliant attainments in a deeper stratum. The hair with its large and deep follicles, sebaceous follicles, all favorable harbingers of filth, was not suspected. With this knowledge of the disease, and our advancement in bacterial therapeutics, we are enabled to formulate a rational plan of treatment; and I am happy to say practice bears evidence of the correctness of our conclusions. In the management of erysipelas our treatment should be preventive if possible.

1. By all means in our power—and this especially refers to aseptic and antiseptic precautions—prevent the introduction of the poison into the wound.

2. If from reasons beyond our control, such as have been enumerated, the poison has gained entrance to the wound, we still have in antiseptic methods a hope of elimination.

3. With a knowledge of the systemic conditions which render the individual peculiarly susceptible to the influence of the poison, we may by suitable remedies assist nature to strengthen vital resistance.

As to the first point in the treatment, it belongs to the domain of prophylaxis, and little need be said. Any of the usual antiseptic methods of wound treatment, if properly executed, will prevent the development of erysipelas in a wound. When the wound is once infected—and this applies to small abrasions with extensive involvement of skin, as in facial erysipelas—what antiseptic agent is best to use? There seems to be a wide-spread error among many physicians that we have so many agents of this class of certain tested potency, this potency of destruction applying to germ-life generally and indiscriminately, and that we can take our little list and select this or that agent according to our choice, and simply be guided by its general potency in the tested scale.

Even at this day of advanced bacteriological research it is not uncommon to hear physicians say, "I think iodoform the best antiseptic;" while others will say, "I think corrosive sublimate the best." Again, we

have the man who adopts as the best that which is newest, and is enthusiastic in favor of naphthol or creolin.

Bacteriological research tends more and more to establish the fact that the various antiseptic agents have their especial application to bacteria life. My experience has been that of Fehleisen and others, that carbolic acid possesses over the micrococcus of erysipelas a more marked effect than any agent, not excepting the sublimate.

Fehleisen found a three-per-cent solution sufficient to kill the micrococcus when brought in contact with it. I have repeatedly observed a solution in glycerine and water of this strength to limit to a marked degree the development of erysipelas in tissue removed some distance from the point of inoculation. The practical consideration as well as great difficulty is to bring the agent in contact with the germs which are buried in tissue surrounding the wound. To meet this, the hypodermic injection of the acid in the skin immediately surrounding the red line of inflammation has been practiced, and it is claimed with good result. This is usually impracticable except in rare cases of very limited infiltration, and must be abandoned in favor of a less radical yet highly satisfactory application of this agent. It is my custom to apply at point of infection—if in facial erysipelas, at the little scratch which can nearly always be found as the point of inoculation—a five-per-cent solution of acid. If a larger wound, it is to be thoroughly cleansed with the same after all pus-pockets are evacuated. The wound and surrounding erysipelatous skin are then covered with gauze or absorbent cotton wrung out of a three-per-cent or weaker solution of acid, and over this is put a dry bandage. By this means a kind of poultice action is produced, the pores of the skin are dilated, the vapor of the acid permeates to the best advantage. If there is suppuration the dressing must be changed three times a day if twice a day is not sufficient. The local anesthetic effect of the acid renders this a most soothing application. As to its ability thus applied to influence the progress of the

disease, a sufficient trial will demonstrate that it does.

Fehleisen found, on examining tissue infiltrated with erysipelas, that the micrococci were congregated around the lymph channels and did not pervade the intervening tissue. The superficial net-work of lymphatic capillaries are so closely applied to the surface of the skin follicles that, were the latter so dilated as to permit the introduction of the carbolic acid, it is easy to see how this agent could retard at least the growth of the micrococci around the lymphatic. I have in severe cases of erysipelas involving a limb, where skin tension was so great as to cause intense pain, and where suppuration was only a question of a few hours, applied cloths from hot water impregnated with carbolic acid. After a very short time relief would ensue, and if applied soon enough prevent abscess. Unfortunately this dressing is more difficult to apply to the face than to other parts of the body. I have never observed any evidence of toxic effects even while nearly one third of the body was enveloped. It is not claimed for this treatment that it will at once cut short the disease (though this is possible in some cases), but that it brings comfort, obviates abscess, and lessens the duration of the affection. Compared with the usual local remedies, as iodine, lead and opium, zinc ointment, solution of iron, etc., it is one of the greatest advances in therapeutics. In regard to the internal medication of erysipelas little need be said. In cases where suppuration does not occur, our aim should be to simply put the alimentary canal in good condition, favor healthy excretion, and give some light chalybeate such as an elixir of calisaya with a small amount of iron. In our climate there will be usually a demand for quinine in some stage of the disease. Very light stimulation is admissible. In the severe cases characterized by pus formation, and where the micrococci have been transplanted by the blood to distant parts (so-called metastatic or pyemic abscess), a vigorous course of stimulation and vicarious nourishment may be necessary to save the patient. I am sat-

isfied that the routine practice of stuffing every erysipelatous patient with tincture of iron, regardless of stomach derangement, is a great error, and by interfering with the taking of food does harm. In mild cases look to elimination, in severe ones to elimination and sustaining the patient against the great draft upon his vital force.

LOUISVILLE, KY.

### STERILITY IN WOMAN: ITS ETIOLOGY AND TREATMENT.

Before the Mississippi Valley Medical Association at Evansville, Ind., September 10, 1889, Dr. E. S. McKee, of Cincinnati, read a paper on this subject of which the following is the author's abstract:

I found the subject a difficult one. The etiology of primary sterility is often "shrouded in darkness," and the successful treatment of the same "past finding out." It was first necessary to eliminate sterility in man. This was of much more frequent occurrence than was formerly thought, but hardly so frequent as claimed by Gross, one out of six cases, or as by Kehrler, "that in at least one third of the cases of sterile marriages, the husband was the party at fault, and gonorrhea the cause of the barrenness." The most common origin of sterility, he thought, was intra-uterine disease; chronic endometritis was its general manifestation. Inflammations of the pelvic peritoneum and of the parametra, or rather their consequences, are among frequent causes. We must determine: Are spermatozoa in these semen; do they get into the utero-cervical canal; do the vaginal secretions poison the spermatozoa? The size of the healthy spermatozoid, its rate of travel and duration of life, would lead us to doubt if stenosis or flexion could primarily have much to do with sterility, and would lead us to lay the blame almost entirely at the door of the vaginal secretions usually found in these cases. The well known infertility of heifers is probably due to an apparent contradiction of terms, viz., inherited sterility. The orgasm in the female, on account of her

being less passionate than the male, is apt to come later with her than with him. Would the male not be too impatient, and endeavor to rouse the passions of the female before attempting the sexual act, the orgasms would come nearer together, and impregnation be more likely to follow. The injurious effect of excessive flesh in women as regards child-bearing has been universally admitted, and is corroborated in experience with plants and lower animals. The prospects of offspring will depend more on the menses than the amount of fat, amenorrhœic fat women being usually sterile. The habits of the wealthy diminish fertility, while those of the poorer classes seem to favor it. The proportion of births is stated by Marshall Hall to be 6 to 1. That the higher education of woman diminishes the number of children born he thought hardly proven as yet. The great prevalence of spasmodic dysmenorrhœa among sterile women, about two out of five cases, leads us to believe that this condition has some influence in producing this result. Gonorrhœa is an important factor, but it has not been proven that every woman who has gonorrhœa is sterile. The truth is, if she had gonorrhœal salpingitis, sterility is the consequence. The reflux of semen is not so frequently a cause as is supposed by many women. The mucous discharges of the glands of Cowper and Duvernay are often mistaken for semen. The vaginal secretion under certain pathological conditions becomes so acid that it kills the spermatozoa. A Chicago professor has found, in that city, that the hair on the pubes of the women who are sterile is straight. He does not say that curling the hair will cure the sterility. Sexual incompatability is well known to exist. More women who marry between the ages of fifteen and twenty are sterile than those who marry after twenty. Many women who have no passion conceive rapidly, others who have may not conceive at all. Tannin or tea-drinking, also sulphur, are thought to have an effect on sterility. Sterility may be occasioned when necessary by obliterating the uterine extremities of the fallopian tubes by the thermo-cautery. Mantagazza,

Boudin, and Balley wrote that consanguineous marriages tend toward sterility. Darwin finds consanguineous marriages slightly more fertile than non consanguineous. He thinks this is because these marriages are more apt to take place where there are large families of cousins, and in this way fertility becomes hereditary. Infertility in these marriages has not been proven.

The cure of sterility is not one of the easy and most encouraging tasks in gynecology. Our imperfect knowledge of the cause is the root of the trouble. Logic here, as in many other departments of therapeutics, has not been closely followed. *Post hoc* and *propter hoc* have been confused. A coincidence has too often been considered a consequence, for in the present age, as in the past, the reputation of remedies is based more upon faith than evidence. We should understand the nature of the trouble in hand, the remedies to combat it, and then place a limit to our faith and expectations. Women addicted to alcohol have become pregnant on adopting habits of teetotalism. Obesity is treated by a rigid diet; if the obesity diminishes, the menses increase, and the woman frequently conceives. A hyperæsthetic condition of the vagina sometimes necessitates anesthetization, the so-called ethereal connection; and if sexual intercourse is thus perfected once or twice, there will seldom be trouble afterward. The more radical treatment of endometritis during recent years promises a more favorable prognosis for sterility due to this trouble than formerly. Women frequently conceive after curetting the uterus for endometritis. The author had experienced good results from a solution consisting of perchloride of iron one part, glycerine three parts, painted in the cervical canal in chronic cervical endometritis. Constitutional treatment is often effective. Both rapid and slow dilatation of the cervix are temporarily successful, and both are generally followed sooner or later by a return of the stenosis. Dysmenorrhœa is relieved in a larger or smaller number of cases. A few cases are followed by endometritis, pelvic cellulitis or peritonitis. Dysmenorrhœa dis-

appears in many, and sterility in a small number of instances. Outerbridge has introduced a new instrument for the cure of sterility. It consists of a steel wire, gold or silver plated, with a slight eversion at one end, with the other bent at right angles. This is inserted into the cervix.

Catheterization of the fallopian tubes is feasible and effective in the hands of some. Sea-bathing, residence at watering places, and the use of mineral waters has a very beneficial effect on many stubborn cases. The crystalline phosphate of zinc,  $\frac{1}{2}$  grain morning and evening, is highly recommended. Avoid tea-drinking and the indigestion of tannin and sulphur. According to Sohns-tein there are times with every woman which we may call the period of predilection for fecundation. Belladonna has the reputation of promoting conception, but has not been very successful in his hands. If outflow of semen from the vagina is one of the troubles, the patient should have her hips elevated during coition, the penis should be allowed to remain as long as possible in the vagina, forming an obstacle to the escape of the semen, and the legs should be crossed so as to help retain it. The taking of the knee chest position immediately after coitus is a good thing and perineorrhaphy is sometimes necessary. Artificial impregnation should be done as a last resort in otherwise hopeless cases. If properly carried out it is not dangerous to life. There are no real moral reasons against it, but it is disagreeable to all concerned. Marion Sims, who first used this method, had a result only once in twenty-seven cases. Absence or paucity of zoöperms, or the presence of many dead or deformed ones, and especially the presence of pus cells contra-indicate the operation. An alkaline vaginal injection of phosphate of soda should precede the operation, to neutralize the effect of the vaginal secretions. Sexual intercourse should then take place promptly, as the secretions may be reproduced. The syringe, new and free from infecting matter, should be brought exactly to the temperature of the body, the semen taken up carefully, the nozzle inserted clear to the

fundus, and the fluid injected. If the wife object to the physician's impregnating her, the husband can be carefully instructed and may be able to carry it out himself.

### CONSTIPATION IN CHILDHOOD FOLLOWING DIARRHEA.\*

BY GEORGE W. VERNON, M. D.

The prognosis in not a few diseases is more grave when occurring in either extreme of life than when occurring in the middle-aged. This is due in great measure to the rapid growth and development of tissues, organs, and glands in early life, and the atrophic and degenerative textural changes which old age induces in the organism. Hence infantile and senile pathology present difficulties of a special kind, which can be understood only by intimate acquaintance with their peculiar characteristics.

The importance of these facts is becoming recognized more and more each year and some of the best talent in the profession, both at home and abroad, is engaged in the elucidation of some of the abstruse problems connected with disease of these periods of life.

One of the diseases deserving of a place in the foregoing category is the constipation of childhood: important, not only on account of the great diversity of the causes which produce it, and the almost innumerable remedies which from time to time have been recommended for its relief or cure, but because there is a great tendency on the part of both parents and physicians to neglect it until it begins to make visible inroads on the general health of the child (or perhaps the physician's attention is not called to it until that time), when organic changes have taken place in the bowel, with disordered functions in other organs, chronic fecal poisoning, and even fatal complications in some cases. While the present health and comfort of the child are affected in nearly

\*Read before the Mississippi Valley Medical Society, September, 1886.

every case, yet this is not of as great moment as the result the constipation will have on the future development and the working conditions of the intestinal tract during the whole of after-life, not only being a source of trouble, worry, and sometimes of grave anxiety, but so affecting the general health as to make the prognosis more doubtful in any disease which may subsequently attack the child.

The factors concerned in the causation of constipation in childhood are so many, so varying in degree and so generally understood, that it would be folly for me to take up the time of this Association in reviewing them all. Hence, I will limit my further remarks to a single branch of the subject, viz., that form of constipation which follows diarrhea. The limited experience afforded by a private practice has convinced me that not a few cases of constipation in childhood are directly traceable to a more or less prolonged diarrhea, occurring some time during the first three or four years of life; and not only is this true in the child, but I believe that many of the cases of alternating constipation and diarrhea in the adult are due to the same cause, which has produced permanent lesions or deformity in the bowel.

My attention was first called to this cause by the following case: M. N., aged five years and a half, was brought to me in September, 1886, for attacks of headache, anorexia, and insomnia.

These attacks had been observed by the mother for about two years, very mild at first, and occurring every five or six weeks, but gradually becoming more severe, and coming on every two or three weeks. The child was badly nourished, tongue coated, breath offensive, abdomen distended, and the bowels extremely constipated, sometimes not acting for four or five days unless some laxative or cathartic was given. As in nearly all these cases, the mother had exhausted all the domestic remedies and patent nostrums for the relief of the various symptoms, each attempt only leaving the child in a worse condition than before. In

the last six or eight attacks there had been great annoyance from retention of urine, which had been relieved each time by the application of cloths, wrung out of cold water, over the region of the bladder. I could find nothing in the habits, hygiene, or diet that gave me any clue to the cause. There had been no previous illness except a diarrhea during the "second summer," lasting, with greater or less severity, from the middle of June until about the first of October, and within a few weeks following the cessation of the diarrhea a sluggish condition of the bowels was noticed, which had become gradually worse until the present visit. The plan of treatment advocated later on in this paper so far relieved the constipation, and with it the concomitant symptoms, that I saw the patient but twice afterward, at intervals of about two weeks each time, until the latter part of the following January (1887), when I found it suffering with broncho-pneumonia following measles, of which it died. With the greatest reluctance on the part of the mother, I was allowed to make an incomplete autopsy five hours after death. The points observed pertaining to this subject were as follows: The caliber of the entire intestinal tract, and especially the large intestine, was much larger than in any other child of near the same age which I have ever examined. There was a broad U-shaped curve in the transverse colon, the apex of which was one inch and three quarters lower than a line drawn from the hepatic to the splenic flexure; the cecum was very much dilated, and its lower and inner surface came in contact with the right side of the summit of the bladder when the latter organ was distended by an injection of water. The mucous surface of the bowel was not examined.

I have the notes (excepting of the autopsies, which have not been made,) of several other cases since the above, which I think are directly traceable to diarrhea as a cause, but time will not permit of their introduction here. The question may arise in the minds of some, how can diarrhea

cause constipation, as the one is exactly the opposite of the other? I might answer that it is the old story of the pendulum swinging from one extreme to the other, but there is a better reason, a scientific, a physiological reason.

The constant and continuous irritation of both the muscles and the nerves of the bowels in a prolonged diarrhea is followed by exhaustion and diminution of irritability. The muscles which have been overstimulated and overworked become tired out, and lose their inherent irritability, their tonicity. Without discussing the part taken by the so-called trophic nerves in the nutrition of the muscle, we will be safe in saying that one of the most important agencies in the restoration of the muscle is materially interfered with, viz., the blood. Not only is there anemia, under which circumstances the muscle does not receive sufficient nourishment, but there is a sluggish circulation both of blood and lymph, which retards the removal of the waste products, which are of themselves depressing and exhausting. Again, the order in which the several muscles of man lose their contractility after death is, first, the left ventricle, then the large intestine, then the small intestine, and so on. Reasoning from analogy, are we not justified in the conclusion that the muscles of the bowels lose their tonicity during life more readily than any other muscle except the left ventricle?

The same causes (constant irritation, etc.) which produce loss of tonicity in the muscle of the bowel will apply with equal force in the production of loss of irritability in the nerves which are so abundantly supplied to them. Then there is the effect on the nerves produced by the change in temperature. Cold diminishes the excitability of nerves. Many of the cases of diarrhea do not subside until the cool weather of October. No precautions are taken to protect the abdomen from becoming chilled by sudden changes from warm to cold which occur at this time of year. The cold comes, the abdomen is chilled, the nerves already below

par are still further depressed by the effects of the cold. Not only that, but the effect produced upon the ganglia of Auerbach and Meissner's plexuses, and reflected through the great solar plexus, will account for the great number of reflex phenomena found in these cases. This leads me directly to the consideration of one symptom which I have noticed in some of the more aggravated cases, viz., the retention of urine. At first I attributed it to the direct pressure of the distended bowel upon the bladder, causing vesical irritation and spasm of the vesical sphincter. But later on, at the suggestion of Dr. W. H. Thomas, of Indianapolis, I was led to look to another source for an explanation of this symptom. While I have not completed my investigations in this line, I will submit the following for your consideration: The ano-spinal center, which controls the act of defecation, and the vesico-spinal center, which regulates micturition, are situated close together in the lumbar region of the cord. I suggest the possibility of a connection between these two centers through which reflex impulses are transmitted. As evidence of this, we may cite the fact that, as a rule, defecation is accompanied or immediately followed by micturition, and although the bladder may have been emptied only a few minutes before defecation, yet there will be the passage of a few drops of urine during the latter act. Again, I do not believe it possible to voluntarily contract the anal sphincter without at the same instant contracting the vesical sphincter. If this be true, is there not some connection between the two? If so, in cases of prolonged constipation, where there is no stimulation to the anal sphincter, no impulse is conveyed to the ano-spinal center, and none can be reflected from it to the vesico-spinal center, thus depriving the latter of a stimulant which, under normal conditions, it would receive one or more times each twenty four hours. Further circumstantial evidence of this theory is, that in all the cases where I have noticed this symptom it disappeared as soon as the constipation was relieved. Only last week I

noticed a tendency to this same symptom in a case of acute constipation in a girl thirteen years old, which disappeared as soon as the bowel was unloaded.

Stating it briefly, then, we have constipation from atony and paresis of the muscles and nerves of the bowel—caused by the excessive and continued irritation of a diarrhea—in which there is diminished peristaltic action, accumulation of feces, dilatation of the entire bowel, or great dilatation of certain parts, which become displaced by their weight, reflex symptoms, and interference with the proper performance of other functions from lack of reflex stimulation.

This being the condition of the intestinal tract, the treatment naturally suggests itself—not stimulating or drastic cathartics, for they only “add fuel to the flame,” but tonics. As in the treatment of any disease, careful directions should be given for the correction of any existing defects in hygiene, clothing, and diet, all of which are found in any of the modern works on the diseases of children. One thing, however, I wish to mention under the head of clothing, that is the use of a flannel bandage, or, what is better, a snug fitting flannel jacket around the abdomen; this can be made out of light-weight goods in summer and heavy in winter. It answers a triple purpose: (1) It protects the abdominal walls, and viscera as well, from becoming chilled by any sudden changes in the weather, which we are liable to have any time of year in our climate; (2) it supports the abdominal walls, which in many cases are flabby and in an atonic condition from distension; (3) the very support given and pressure made on the abdominal walls acts as a tonic to the nerves supplying them, and through them impulses are reflected to the nerves going to the bowels, setting up contractions there.

It is my habit in all these cases to thoroughly evacuate the bowels; to accomplish which nothing has acted so well in my hands as one-tenth-grain doses of calomel, repeated every two hours until four or five

doses are given, to be followed in six or eight hours by some of the milder salines or laxative waters.

The bowels being thoroughly cleaned out, a very important point will be gained by having a regular time each day to go to stool. Direct the injection of one dram of pure, undiluted glycerine, or the introduction of a glycerine suppository into the rectum at a certain time each day; this will be followed in from fifteen minutes to two hours by an action of the bowels. This can be continued, as necessary, until the tonics begin to have their effect; in the mean time you have done much toward establishing the habit of regular stools.

The tonics from which I have derived most benefit are, in the order of their value in these cases, strychnia, ergot, phosphorus, and iron. Sometimes these are given singly and sometimes combined with other agents as the indications may require. As there is usually anemia, some of the least astringent preparations of iron in combination with strychnia, in doses suitable to the age of the child, will act well from the first. Several times I have used Hammond's mixture with excellent results; in this you get strychnia, iron, quinine, and phosphoric acid all in the same mixture.

In addition to such agents as have been mentioned, great benefit will be derived from the systematic use of massage, not applied to the abdomen only, but to the entire body; also from the use of electricity in the form of the constant current.

This paper would be incomplete did it fail to call attention to the very important subject of prophylaxis. At least three fourths of these cases could be prevented if the physician would follow up his cases of diarrhea with the proper treatment. We are not justified in dismissing our cases of diarrhea as soon as the bowels are checked, especially where it has continued some length of time.

We would not dismiss a case of typhoid fever as soon as the fever disappeared, but would watch it carefully for some time, using such agents as would assist in the

complete restoration to as near perfect health as possible. The same rule applies with equal force in the diarrheas of childhood. The child is not well when the discharges from the bowels cease, but the entire machinery of the body is weakened from the strain it has received. The anemia, general debility, weakened digestive power, and atony of the bowels, each presents itself for due consideration, and the proper remedy for its relief would be indicated on general principles. By thus watching these cases until the return of perfect health we reach the highest aim of the modern physician, prevention of disease.

INDIANAPOLIS, IND.

## Societies.

### LOUISVILLE SURGICAL SOCIETY.

Stated Meeting, September 16, 1889, Dr. W. Cheatham, President pro tem., in the chair.

Dr. W. O. Roberts reported a resection of the knee, done on a boy (eighteen years) for a white swelling. There was an opening, with purulent discharge. When this was closed there was great suffering. The speaker tried fixed dressing without avail, and finally decided to resect the joint. The cartilages were gone. The patella, condyles of the femur, and articular portion of the tibia were removed to the extent of a half inch on each side. The dressing was fixed and antiseptic. After twelve hours the temperature was only 95°. Notwithstanding antiseptic precautions, in a week pus was found on removal of the dressing; much pus followed in the course of repair, but recovery was perfect. The patient had considerable motion in the joint until July last (operation was done in February). There is now slight motion only. He uses no crutch, but wears a leather brace. He is decidedly strumous. The bone was very soft. The patient was much emaciated at the time of the operation; he is now in good flesh. The disease had existed for eighteen months before the operation.

Dr. Ap M. Vance thinks there is fibrous union between the bones.

Dr. A. M. Cartledge: Did you use drainage?

Dr. Roberts: Yes, at each angle, but not clear through.

Dr. Cartledge has changed opinion relative to the treatment of these cases; he used to favor amputation but now resects.

Dr. Vance thinks that by amputation we get rid of the diathesis. An artificial limb generally does good service. He once resected in a case the subject of which could not afford to buy an artificial limb. Obstructive gangrene supervened, but by aseptic handling the limb was saved. There was no swelling, and bony union became established.

Dr. E. R. Palmer asked if a microscopic examination was made.

Answer: "No."

Dr. Cartledge: Is such resection more favorable at this age (eighteen years) than later?

Dr. Roberts thinks that where the disease goes beyond the cartilage there is danger, in removing the epiphyses, of stopping the growth of the bone longitudinally. Billroth says we may get bony union at first, and later in life get a joint that is movable too. At each dressing a 1-2,000 bichloride solution was used. This ought to have destroyed the pyogenic microbes.

Dr. H. H. Grant thinks a 1-2,000 bichloride solution not strong enough for the purpose.

Dr. Cartledge would favor in arthrotomy the introduction of a drainage-tube and subsequent washing with a bichloride solution.

Dr. Roberts said, *a la* Gerster, that he would tuck in the skin to keep patulous an opening in a sinus rather than use a drainage-tube. Drainage-tubes do harm by making pressure on the tissues which hold them and by becoming occluded. Sometimes they are the carriers of septic material into the wound. I saw geese-quills used in the Massachusetts General Hospital. I like them; they are not so apt to collapse as other tubes. I don't like the decalcified bone tubes; we are not certain they are completely decalcified.

I once had to open and remove a non-decalcified tube that had formed an abscess in a wound.

Dr. Roberts had formerly reported the removal of nine large stones from the female bladder by dilatation of the urethra. A question came up at the time as to subsequent incontinence. The rule is not to dilate if the stone is more than an inch in diameter. In this case he dilated by the rapid method and removed stones of more than an inch in diameter. Two weeks afterward there was complete incontinence, but in six weeks continence was fully restored. In a case of another surgeon, who had removed one stone one inch and a quarter in diameter by rapid dilatation, there is incontinence after many months.

Dr. A. M. Cartledge read a paper on the treatment of erysipelas. (See page 289.) The author supplemented his paper with a report of ten cases treated last spring, cases existing when he was called. He continued to do surgical operations, nevertheless, and has had no erysipelas in his surgical practice.

Dr. Ap M. Vance said he had used carbolic acid as the author advises, but prefers glycerine to water as a menstruum. Thinks glycerine depletes locally. He had had a number of cases of threatened phlegmon of fingers and hands which had been aborted by painting with pure carbolic acid. Those not so treated went on to suppuration. It is possible that carbolic acid constricts the blood-vessels, and so starves the microbes by keeping blood away.

Dr. W. O. Roberts inclined to the view that the disease is always due to trauma, yet he has had cases wherein not the slightest abrasion could be found. When confined to the skin the disease gets well under any treatment. Where tension is moderate, carbolic acid, pressure, and rest will cause the local trouble to subside with wonderful rapidity. In cellular erysipelas there is great tension and generally bad results. Free incisions should be made to avoid sloughing. These incisions the speaker always washes with 1-20 carbol. He does not agree with the essayist as to the value

of quinine and iron. He always prescribes *mur. tinct. of iron and quinine* in full doses. Alcohol is given if needed, and the bowels are kept open with laxatives. Iodine may be used locally with advantage.

Dr. H. H. Grant said that the essayist's views were advanced. As to the non traumatic origin of erysipelas, those who believe in the germ theory must believe in internal infection. Even hip-joint disease is held by some to be due to a bacillus which finds entrance through the skin. The development of the disease depends upon the condition of the fluid serum as a nidus for the germs. No application will destroy the microbes, but it may destroy them by rendering inert their culture-field. Caustics only would destroy the germs, but these would also destroy the tissues. Internal treatment is useful, and may be justified theoretically and practically. I give *tr. fer. chlor.* as a constructive and alterative. *Jaborandi* I give as an eliminative of the poison. Quinine is always indicated.

Dr. Palmer: The good attained from the use of muriated tincture of iron is believed by some to be due to the specific action of the chloric ether which is by this means introduced into the blood. So far as killing the resistant microbe is concerned, it is not the microbe, but its ptomaine that does the harm, and this alkaloidal product of germ-life may be rendered innocuous by antiseptics that will not destroy the germ itself. It is in this that the value of iodoform resides. If carbolic acid is a specific of peculiar benefit in erysipelas and phlegmon, it must be by its action destructive of the ptomaine.

Dr. W. Cheatham said he had never had erysipelas to follow operations on the eye.

Dr. Cartledge said that if iodine did any good it was by its antiseptic action. He uses glycerine as a menstruum, and, like Dr. Vance, has been able to abort boils, carbuncles, etc. He must believe that an abrasion, or at least a pimple or a scratch must exist before the poison of erysipelas can enter the system. He believes cutaneous and cellular erysipelas to be identical. He has often seen cases of erysipelas side by side with

patients having wounds, and yet the latter did not contract the disease. Two conditions are required for infection in all germ diseases, the poison and a predisposing state of the subject. He agrees with Dr. Palmer, that we must destroy the ptomaine to cure the disease. There may be something in the chlorine theory, that free chlorine escapes from muriated tincture of iron, forming chloric ether with the alcohol, which kills the germ, but he doubts its truth. He does not think there is any thing in the iron; would rather give milk than iron for blood-making.

Dr. Ap M. Vance reported a case of a boy who four weeks ago fell from a tree, a distance of ten feet, breaking both bones of the fore-arm at the wrist and sustaining a compound dislocation of the elbow. There was four inches protrusion. The hand was blue. He set the fracture and found no radial pulse. He then reduced the luxation, when the pulse returned. The limb was dressed antiseptically; no drainage, no stretcher. Temperature never rose above 100°. There was no swelling, and no pus formed. The patient has now voluntary motion. A 1-5,000 bichloride solution was applied to the wound. Considerable hemorrhage accompanied the manipulation of the injury. I never had a simple luxation of the elbow without swelling. I took the dressing off on the thirteenth day; a red line of union persisted for three weeks. This case would seem to show that we can save any compound injury about joints.

Dr. Roberts said that whenever the pulsation in a limb so injured returns he would try to save it, but if no pulse could be felt it would be useless.

E. R. PALMER, M. D.,  
*Secretary.*

CARDIAC DISPLACEMENT.—“Were you wounded in the Crimea, Pat?”

“No, yer honor; the bullet hit me in the chest and kem out at me back.”

“Why, Pat, that would have gone right through your heart.”

“Och, faix, me heart was in me mouth.”

## Reviews and Bibliography.

**A Treatise on the Science and Practice of Midwifery.** By W. S. PLAYFAIR, M.D., LL.D., F.R.C.P. Fifth American from the seventh English edition, with Notes and Additions, by ROBERT P. HARRIS, M.D., with five plates and two hundred and seven illustrations. 671 pp. Philadelphia: Lea Brothers & Co. 1882.

In the science as well as in the practice of obstetrics the leading principles are so well settled that no work pretending to be a text book fails to meet their requirements, yet of the various standard works each has some peculiar excellency. That which distinguishes Playfair is clearness of statement, freedom from redundancy and elegance of diction. Of all obstetric works by English-speaking authors, we think none surpasses Playfair in the way of attractive reading. In points where the English practice and the American differ, the American editor has pointed out the difference and obviated difficulties that might otherwise have arisen. He has also given the latest conclusions in regard to cesarean section, Porro's operation, exsection in extra-uterine pregnancy, and other recently mooted points in obstetric surgery.

Into the department of physics, as applied to the explanation of phenomena in the mechanism of labor, so much elaborated of late by German authors, and notably by Galabin in England, the author has scarcely entered, except to give the well-known examples contained in all text-books on midwifery.

To some of the conclusions the author accepts (for he presents few of his own) the writer would call attention in the way of criticism, believing as he does that the accepted teachings are erroneous in regard to the causes of presentation, rotation, and also extension.

It has for some years been the opinion of the writer that the cause of head presentations is the diving movements which necessarily result from the instinctive movements of the legs, coupled with the increasing conicalness of the lower segment of the

uterus during the latter months of pregnancy. This is the only explanation that takes cognizance of the fact that the young of lower animals are as uniformly born with the head presenting as are children. The natural instinctive movements of the child cause it to swim downward to the outlet; those of the young animal cause it to swim upward to the outlet.

While concurring with the author in the view that his silence on this point leaves us to infer that he takes, viz., that all explanations of this phenomenon hitherto given are unsatisfactory, it hardly seems admissible for the author of a text-book to pass over in silence a question that for more than twenty centuries has called forth the best efforts of medical philosophers.

The author's position as to the physical principles involved in rotation we feel constrained to question. Two causes are ascribed as operative in producing rotation. One is the projection inward of the ischial spines, which narrow the transverse diameter of the pelvic outlet, and the other is that of the German obstetricians, who refer the change to the increased resistance the head meets from the posterior wall of the pelvis and from the perineal structures. By most German obstetricians, says the author, the influence of the ischial spines and of the smooth pelvic planes in influencing rotation is not admitted. And may they not with reason not admit it? In the experiment of Dubois, made by pressing a child through the pelvis of the dead mother, the head was observed to rotate for one or two times, while after that it passed through without rotation. It is obvious that the soft parts must have been made more yielding by the repeated pressure, while the spines remained rigid. Now, if the ischial spines caused rotation at first, they ought the more to have caused it subsequently to the kneading of the soft parts.

This supposed factor being disposed of, let us see how much more there is in the second, viz., that rotation is caused by the increased resistance the head meets from the posterior wall of the pelvis and from the perineal

structures, the resistance of these being assumed to be much greater than that of the anterior part of the pelvis. Elsewhere it is contended that the first part of the head that meets the resistance of the floor of the pelvis is pushed forward. To illustrate the method of this assumed action, let us suppose a boot-tree is taken and suspended perpendicularly on a shaft passing up through the leg, and about which it can freely play. Thus hung, let it be moved forward by a force applied to the shaft, with the toe sliding on the floor. Now, if the toe of this boot-tree will move in advance, so will the presenting part of the child's head. But in neither case would this be the result of such forces. Beyond doubt the resistance of the posterior wall of the pelvis is less than that of the anterior, because its gradient is less; the curve to be made around the pubis is much sharper than that along the sacrum. How then can rotation be accounted for? Why, simply by supposing that the roughest and consequently most resisting part of the ovoid seeks the easiest part of the passage, viz., the posterior part. In vertex presentations the face of the child presents the roughest surface, and the face consequently is pushed away from the more resisting pubis to the less resisting sacrum. In case of a face presentation, the occiput being borne back between the shoulders, the roughness of the face operates in favor of the posterior half of the fetal ovoid, and as a consequence the forehead turns backward and the chin forward, and as a result the back of the child is turned to that of the mother. Whether this is the true explanation or not, it is simple and easily remembered. Briefly stated, it is simply this: *Whichever is the roughest half of the presenting extremity of the fetal ovoid will turn posteriorly by the shortest route.* Of course there are points of simple adaptation which this rule is not needed to elucidate. We incline to think also that something might be added to the explanation of extension.

The author says: "The occiput is forced down by the pains, and in consequence of its altered position is enabled to pass be-

tween the rami of the pubis, and advances until its further descent is checked by the nape of the neck, which is pressed under and against the arch of the pubes. By this means the occiput is fixed, and the pains continuing, the uterine force no longer acts on the occiput, but on the anterior part of the head, which is now pushed down and separated from the sternum." This is at best an insufficient explanation. It seems to us indispensable that, after flexion has been produced, extension could not take place without a change in the relation of the diameter of the fetal head to that of the pelvis. This is effected in part by the escape forward of the occiput, and in part by the pressing backward of the coccyx with its attached muscles, allowing the rotation of the head about its transverse diameter. In this way room is made for the largest diameters of the fetal head.

These criticisms, if just, apply not more to Playfair than to the whole of the standard works on obstetrics.

On the whole it is an excellent work, and we could not advise the student who does not wish to make a specialty of the branch to pass by this for any other. D. T. S.

**The Operations of Surgery.** A systematic Handbook for Practitioners, Students, and Hospital Surgeons. By W. H. A. JACOBSON, F. R. C. S. With one hundred and ninety-nine illustrations. 995 pp. Price, cloth, \$5.00; leather, \$6.00. Philadelphia: P. Blakiston, Son & Co. 1889.

This book is the outcome of a conviction on the part of the author, that a work which aimed at being more comprehensive in scope and fuller in detail than those already published would be of service to practitioners and students, and the result must prove that he has not been at fault in his convictions.

It is not merely the mode and technique of the operation that the author carefully elucidates, but the indications for the operation, and the complications likely to be met with are all set forth in a singularly clear and impressive style. While rarely a surgeon can be found who may not find the lessons of its pages eminently helpful, to those practition-

ers outside of cities, who must often assume responsibilities of a trying character in surgical practice, it must prove a treasure trove. For such a one must feel that he has by him a counselor who can supply every thing necessary but skill. D. T. S.

**A Treatise on Surgery, its Principles and Practice.** By T. HOLMES, M. A., Cantab. With four hundred illustrations. Fifth edition, edited by T. PICKERING PRK. 1008 pp. Price, cloth, \$6; leather, \$7.50. Philadelphia: Lea Brothers & Co. 1889.

"This volume," said the eminent author in the preface to his first edition, "is an attempt to represent the present condition of surgery as practiced in this country (England) by a treatise which shall not be unworthy to rank with other text-books in use in our schools." After fourteen years, the editor of the present volume might repeat the language, adding that it has been found worthy to rank with other text-books in use in our schools.

The science and art of surgery have become so vast that no one can any longer dream of equipping the student for every department of it in a volume of a thousand pages, or even two thousand. Each must seek his complete equipment in works designed for his own department. But, first, a general knowledge of the subject must be gained, and for that purpose Holmes' Surgery comes as near embracing the proper scope as any other. Long one of the world's highest authorities, it has not failed to hold its position in the present revised edition.

D. T. S.

**A Guide to Therapeutics and Materia Medica.** By ROBERT FARQUHARSON, M. P., M. D., F. R. C. P., LL. D. Fourth American, from the fourth English edition. Enlarged so as to include all preparations official in the U. S. Pharmacopœia, by FRANK WOODBURY, A. M., M. D. 598 pp. Philadelphia: Lea Brothers & Co. 1889.

Farquharson's Therapeutics and Materia Medica has struck a happy medium between excessive brevity on the one hand and tedi-

ous prolixity on the other. It deals with the entire list of drugs embraced in the British Pharmacopœia in such a way as to give in a satisfactory form the established indications of each, excluding all irrelevant matter. An especially attractive feature is an arrangement by which the physiological and therapeutical action of various remedies are shown in parallel columns. This aids greatly in fixing attention and facilitates study. The American editor has enlarged the work so as to include all the remedies and preparations in the United States Pharmacopœia, and added to the text by various interpolations, some of them it seems to us not exactly in the line of condensation and directness which characterizes the original work. Altogether the book is a most valuable addition to the list of treatises on this most important subject.

D. T. S.

**Essentials of Materia Medica and Therapeutics.** Arranged in the Form of Questions and Answers; prepared especially for Students of Medicine. By HENRY MORRIS, M. D. 250 pp. Price, cloth, \$1.00; interleaved for taking notes, \$1.25. Philadelphia: W. B. Saunders, 1889.

This is No. 7 of Saunders' Question Compend, already so well known to students of medicine. The work, already excellent in the old edition, has been largely improved by the revision it has received at the hands of the author.

D. T. S.

**Materia Medica and Therapeutics for Physicians and Students.** By JOHN B. BIDDLE, M. D. Eleventh edition, revised and enlarged, with special reference to Therapeutics and the Physiological Action of Medicines, by CLEMENT BIDDLE M.D., U.S. Navy, and HENRY MORRIS, M.D. With numerous illustrations. 607 pp. Price, \$4.25. Philadelphia: P. Blakiston, Son & Co. 1889.

When a work has reached its eleventh edition with a discriminating public, there is little need of further review after announcement of this fact. The authors dedicate the work, with each successive edition, to the gentlemen in attendance upon the various medical schools in North America,

and in doing so fitly name the class who are expected to profit most by its study. The matter is full, the type bold, the style smooth, and the arrangement clear. It deals little with intricate and complex questions of physiological action, such as delight advanced medical scholars, but which are apt to prove discouraging to the beginner. It is a capital book for "the gentlemen who are attending the various schools in North America."

D. T. S.

**Synopsis of Human Anatomy.** Being a Complete Compend of Anatomy, including the Anatomy of the Viscera, and numerous Tables. By JAMES K. YOUNG, M. D. 393 pp. Price, \$1.40. Philadelphia and London: F. A. Davis, publisher. 1889.

The object of this little work is to furnish a concise though complete synopsis of human anatomy for the use of students of medicine and others. It is the fullest of all the synopses of this subject we have seen, and no objection would be urged to it as a book of ready reference or for review. A study, however, so difficult as anatomy requires every possible aid, and too much has been gained by the printing of the names of parts in the illustrations, for students to think of beginning the study of anatomy from works that indicate the parts by figures only, which are explained in foot-notes, as is the case with the work before us.

D. T. S.

**On the Treatment of Cystic Goitre.** By T. MARK HOVELL, F. R. C. S. E. 26 pp. Price, one shilling. London: J. & A. Churchill. 1888.

This is a brochure written by the author in advocacy of a treatment of cystic goitre introduced by Sir Morell Mackenzie. This method consists in tapping the cyst in its most dependent part, inserting a canula, and, when the fluid has been withdrawn, injecting into the sac with a syringe a solution of perchloride of iron,  $\text{zij}$  to  $\text{3j}$  of water; then, inserting a plug into the canula, which has previously been secured in position, and allowing it to remain for seventy-two hours—after which time the plug is withdrawn and

not re-introduced if suppuration has taken place—poultices are now applied, and the case treated as one of chronic abscess. The author makes an excellent showing for this procedure.

D. T. S.

**American Resorts:** With Notes Upon Their Climate. By BUSHROD W. JAMES, A. M., M. D., with a translation from the German by Mr. S. KAUFFMAN of those chapters of "Die Klimate der Erde," written by Dr. A. Woeikof, of St. Petersburg, that relate to North and South America and the islands and oceans contiguous thereto. 285 pp. Philadelphia and London: 1889. F. A. Davis.

This work, though avowedly intended for invalids and for those who desire to preserve good health in a suitable climate, is replete of information to be appreciated by every student of the geography and climatology of the American continent. Among other features is a well-executed map showing the location of all the important health resorts in the United States, Canada, and Mexico.

D. T. S.

**The Diagnosis and Treatment of Diseases of the Rectum.** By WILLIAM ALLINGHAM. Edited and revised, with much additional matter and numerous diagrams, by HERBERT WILLIAM ALLINGHAM. Fifth edition. 366 pp. London: J. & A. Churchill. 1889.

Allingham on the Rectum has had rare good fortune in holding its place for a long period as the classic of its department. Not only has it not had to yield its place to any later-coming competitor in the field, but even the introduction of antiseptics into surgery required but little response where antiseptics can seldom be employed with advantage. Whatever changes and improvements may have been needed have been made by the son, by whom the father has the good fortune to be assisted; so it is still "Allingham on the Rectum."

D. T. S.

In future numbers of the National Magazine will appear a symposium comprising articles by prominent scholars and statesmen, giving their opinions on leading questions, such as "Darwin's Theory," "The Chinese Question," "Socialism," and "Should

Immigration be Restricted?" Published the first of each month at 147 Throop Street, Chicago. Subscription price, \$1.00 a year. Sample copy, 10 cents.

The Johns Hopkins Hospital Bulletin. The trustees of the Johns Hopkins Hospital have authorized the issue of a monthly publication, to be known as the Hospital Bulletin. It will contain announcements of courses of lectures, programmes of clinical and pathological study, details of hospital and dispensary practice, abstracts of papers read and other proceedings of the Medical Society of the Hospital, reports of lectures, and all other matters of general interest in connection with the work of the Hospital. Nine numbers will be issued annually. The first number will appear in November, 1889. The subscription price will be one dollar per year. Subscriptions may be sent to the publication agency of the Johns Hopkins University, Baltimore, Md.

**Hypnotism: Its History and Development.** By Fredrik Bjornstrom, M. D., Head Physician of the Stockholm Hospital, Professor of Psychiatry, late Royal Swedish Medical Councilor. Authorized translation from the second Swedish edition, by Baron Nils Posse, M. G., Director of the Boston School of Gymnastics. Paper, price 30 cents. The Humboldt Publishing Co., 28 Lafayette Place, New York. This is a timely book. Last August over one hundred and fifty "savants of incontestible authority" met in Paris to discuss the progress and development of the mysterious agency known as "Hypnotism," and as a result of their deliberations the subject has entered the domain of science, and evidently has come to stay. The author of the present work is well qualified to write on the subject—none better; and we bespeak for the work, which is specially translated for the Humboldt Library of Science, an immediate success.

The Medical News Visiting List for 1890 has been thoroughly revised and brought up to date in every respect. The text portion (48 pages) contains the most useful data for the physician and surgeon, including even the latest therapeutic novelties, their doses and effects, and an alphabetical table of diseases, with the most approved remedies. The classified blanks (176 pages) are arranged to hold records of all kinds of professional work, with memoranda and accounts. Three styles are now published, as heretofore: Weekly (dated for 30 patients); Monthly (undated, for 120 patients per month, and good for any year); and Perpet-

ual (undated, and likewise good for any year); so that the Medical News Visiting List adapts itself to any system of keeping professional accounts. Each style is in one volume, bound in handsome red leather, with pocket and a pencil, at \$1.25. When desired, a Ready-reference Thumb-letter Index is furnished, which is peculiar to this Visiting List, and will save many times its small cost (25 cents) in the economy of time effected during a year. In short, every need of the physician seems to have been anticipated in the Medical News Visiting List.

## Correspondence.

### PARIS LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

At one of the congresses held in Paris on mental diseases, Dr. Fabret, a distinguished alienist, remarked that insanity with consciousness was scarcely admitted by our predecessors, but now, we are obliged to acknowledge that there exist certain forms of mental alienation in which patients perfectly recognize the anomalous nature of the phenomena which they experience, but without being able to disembarass themselves from them. He dwelt on these intellectual obsessions, which are emotive and instinctive or veritable morbid impulsions dominating the will. He cited, among other examples, the obstinate search for words, the fear of a knife, of a window, the terror of open or closed spaces, the necessity for repeating certain words or certain phrases, etc. The intellectual obsessions are ordinarily hereditary, periodical, or remittent. They are accompanied by anguish and a sort of interior struggle, never presenting hallucinations and never ending in dementia. Dr. Magnan, another well-known alienist, considers these states of the mind as mental stigmata of a family nervous defect; the disequilibrium then manifests itself early. The insanity of doubt (*folie du doute*) is the most common expression of this psychical state of degenerated subjects. The patients continually ruminate in their minds over the same ideas and the same acts. They question themselves on every

thing, and have senseless scruples *à propos* of every thing. If the patient is a physician, he doubts the prescriptions that he had just written, and he sends frequently to bring them back, in the fear of having committed some errors. We often meet, in this life, timorous subjects who are perpetually uneasy in mind, and are a prey to what Professor Bull terms a sort of continued "cerebral pruritis." There are also to be met with what are termed "counters," who are continually calculating the number of different objects. There are others who send to the newspapers their phrases *soi-disant* prophetic, particularly at the advent of any great political event. There are other "emotives" again, who walk carefully between the lines of planks put together, or make a vow to touch with the finger all the lamp-posts in the street or all the brass handles of the doors they pass by; they are seized with intense uneasiness when they are unable to satisfy their mania. The insanity of touch (*le délire du toucher*) coincides here with the insanity of doubt and contributes to the morbid obsession and to the melancholic state of these unfortunate creatures, whose lives become as insupportable to those around them as to themselves. Certain forms of impulsions to theft issue from morbid obsessions of this nature, and it is because these obsessions are veritably irresistible that human responsibility is not involved or it is greatly attenuated. Another variety of cerebral degenerated subjects is that which takes the form of jealousy, a subject which was ingeniously treated of by Dr. A. Dorez. Morbid jealousy, he said, is a pathological mental state which implants itself by degrees in the soul of him who loves. The subject soon interprets in the sense of his mania the most insignificant events and facts. Persecuted, he becomes persecutor; he threatens, commits outrages, strikes, and kills. But all these acts bear the stamp of mental disequilibrium in a most manifest manner. His ideas are exaggerated to delirium, erroneous to hallucination. If morbid jealousy, as described by the great

Will, is not precisely insanity, it is on the undefined line which traces the limits between sanity and insanity. In these cases the cerebral weakness is always more marked and the prognosis still more grave. Moreover, there is frequently an organic cause to search for in confirmed sensorial insanity. It is thus that certain lesions of the auditory apparatus produce hallucinations and psychical troubles. The hearing is, according to the definition of Bernardin Saint Pierre, the function the most immediate of intelligence, the intellectual sense *par excellence*. Inflammation of the mucous membrane of the ear and the buzzing noises in that organ often produce spasms, convulsions, and giddiness. But it is hallucinations particularly which appear to be produced by lesions of the ear. Perhaps it is by auditory hallucination that may be explained the demons of Socrates and of Tasse, the diabolical sonata of Tartini, and the interminable discussions which Luther sustained all his life with Malin. It is certain, in fact, with regard to the latter, that he suffered many a time from abscesses in the ears, and that he died deaf. It is true that he was also alcoholic, and this must have greatly contributed to the hallucinatory state of the great reformer. That which proves the necessity for attentively and completely examining all patients is that lunatics have been cured in curing an otitis or removing a foreign body from the ear which entertained the troubles of ideation. Dr. Dorez stated that he lately cured a young girl of cephalalgia of four years' standing, and which was unsuccessfully treated by all sorts of medications, and that by examining the eyes and prescribing appropriate glasses. So it is for certain cases of mental alienation the origin of which an expert physician would trace to some organic lesion. Dr. C. Féré, a distinguished psychiatrist, stated that insanity commences with a false sensation, a belief which soon serves as the foundation of false interpretations, of delusions, of fixed ideas, and of obsessions. "One has never so much to say as when he starts from false principles; the error of the

departure often occasions the running off the rails."

You will have heard of the death of Dr. Ricord, the celebrated syphilographer, which took place at 3 o'clock on Tuesday morning the 22d inst., from an attack of pneumonia. He was in his eighty-ninth year, having been born in 1800 at Baltimore, whither his father had gone to seek his fortune, but unsuccessfully. It was at Baltimore that Dr. Ricord commenced his medical studies, under the direction of his grandfather, who was a Marseillaise physician. At the age of twenty years the young Ricord arrived in France, was admitted to the *Internat* of Hospitals in 1822, and served as *interne* under Dupuytren and Lisfranc, and in 1826 he took his degree of Doctor of Medicine of the Faculty of Paris. His means being very limited, he went to practice in the provinces, where he was rather successful. In 1831 he was, after competition, appointed surgeon to the Hôpital du Midi (the well-known hospital for venereal affections), to which he was attached until the year 1860, when he had to retire, having attained the limit of age allotted to hospital surgeons in this country, but he was allowed to retain the title of Honorary Hospital Surgeon. His lectures and his teaching will long be remembered by the successive generations of medical men who attended them from all parts of the world. These lectures were of an incomparable brilliancy, incomparable by the originality of his views, by the depth of his science, at the same time by his inexhaustible store of wit, which he possessed to a remarkable degree. A collection of his *bons mots* would form a large volume. Ricord was not much given to writing, but he was a successful practitioner, particularly in his specialty, in which he obtained a world-wide reputation. He was much loved, not only by his pupils but by his patients, and it was only within a few days of the fatal illness which he had contracted, about three weeks ago, that he was still seen going about visiting his patients. He was the senior member of the Academy of Medicine, having been elected

in 1850. In 1871 he was nominated Grand Officer of the Legion of Honor for his services during the siege of Paris. He had also received upward of two hundred decorations from all parts of the world.

PARIS, October 25, 1889.

## Abstracts and Selections.

**OBSTETRICS AND GYNECOLOGY.**—(E. S. McKee, M. D., Cincinnati.) The Section on Obstetrics, British Medical Association, had for its president, Dr. C. J. Cullingworth, Obstetric Physician to St. Thomas Hospital, London. He dwelt in his opening address on the great advantages which had flowed from the introduction of the antiseptic method in obstetric practice. He dealt with details of treatment which might be beneficially observed, and spoke of the necessity of simple precautions with respect to newly born children so as to avoid dangers. Reviewing the work about to be done by the session, he referred to the strong differences of opinion among the rival schools, and said that the want of forbearance rose from the fact that the light of scientific inquiry had but recently been brought to bear upon the study of gynecology. We are still in the dark as to the pathology of some of the most common diseases to which woman is subject. Dr. Braxton Hicks, F. R. S., opened a discussion on the treatment of placenta previa.

The Cincinnati Obstetrical Society held its October meeting at the residence of Dr. E. S. McKee. The paper of the evening was read by Dr. E. W. Mitchell on the subject, *The Medical Treatment of Dysmenorrhea*. The doctor handled his subject in a very able manner, and showed an acquaintance with both the theoretical and practical sides which was very great. It would be impossible to give a fair synopsis of the paper and the instructive case reports which it contained. The doctor had gained considerable relief from the use of antipyrine, but failed to attain a permanent cure. Apioi had given satisfaction in his hands. The hygiene of the young girl was a much neglected and very important subject. The paper was very fully discussed by the members of the Society, and some remarks of special value made by Dr. C. D. Palmer. Concentrated tincture of cimicifuga in moderate doses for a few days prior to the period and at frequent intervals during the pain, also the tincture of pulsatilla, had done him

good service. He advised the building up of the general health in every possible way.

Dr. James R. Chadwick, of Boston, conceived and Dr. Fordyce Barker, of New York, generated the American Gynecological Society.

Dr. H. P. C. Wilson, of Baltimore, in his presidential address before the American Gynecological Society was not very friendly toward the new complications into which the Society is becoming entangled with the American Congress of Physicians and Surgeons. He said, "I would restrain this Society from all entangling alliances with other societies. The distractions of such large assemblies are not promotive of the best work in any specialty. If we would make it the great authority on gynecological subjects, if we would make it the first in wisdom as the first in age, we must abstain from too much allegiance to other societies, and let our full strength be concentrated here. Whatever time and labor we spend with them will be subtracted from this, and by so much will its vigor and strength be diminished."

Laparotomy during Menstruation was the subject of the scientific portion of the address of the president of the American Gynecological Society, Dr. H. P. C. Wilson, of Baltimore, at the meeting held at Boston in September, 1889. Shall laparotomy be performed immediately preceding or during menstruation? was a subject which had frequently embarrassed him during his earlier professional career. His experience had taught him that for laparotomies involving the pelvic organs it was better to select the uterine flood than the uterine ebb. During the uterine flood the circulation and innervation are in a state of tonic excitement. During the uterine ebb they are in a state of relaxation and depression. On this account patients are more liable to passive hemorrhages, the absorption of septic poison, the deadly influence of shock; than when the system is under the stimulus of the uterine flood. It might be said that inflammatory troubles are more apt to be set up during the uterine flood, yet he could not recall that he had lost a case of laparotomy by inflammation other than septic. The doctor related two cases in detail in which he had performed laparotomy for ovariectomy during menstruation which came on owing to the excitement of the patient in anticipation of the operation. He said he could relate many cases in which he had performed laparotomy very near or during menstruation, but would not detain the Society. Within

the past year he had done a number of such operations, and every one recovered. He has not lost a case where laparotomy was done immediately before or during a menstruation, and he is forced to make the uterine flood the time of selection for such operations rather than the uterine ebb.

**DIABETES MELLITUS AFTER EXTIRPATION OF THE PANCREAS.**—DRS. V. Mering and O. Minkowski report a large number of experiments from their laboratory at Strasburg, all showing that extirpation of the pancreas results in true diabetes mellitus with all its ordinary symptoms. A dog whose pancreas had been removed secreted, after forty-eight hours' fasting, from five to six per cent of sugar in his urine. Another dog, weighing fifteen lbs., secreted, under an exclusive meat diet, two pints of urine daily, with six to eight per cent of sugar. Introduction of grape sugar into the food resulted in an increase of this by six per cent, by far the greatest part of the grape sugar being excreted without having undergone any modification. The urine also contained appreciable quantities of "acetone." The percentage of sugar in the blood was likewise much increased, being in one case 0.30, in another 0.46. Glycogen at the same time disappeared altogether. In a dog, for instance, which had been diabetic for four weeks, and which was killed while being fed on a full flesh diet, neither liver nor muscle contained glycogen. Transfusion from a diabetic dog caused no secretion of sugar in a healthy dog.—*Lancet*.

**THE NEW TENICIDES.**—*Areca* nuts are brought from India, Ceylon, and the Philippine Islands. The *Areca catechu*, of which they are the fruit, is a palm. Arecaline is the active principle, and it is to this that the tenicide property of areca nuts is due. In its chemical composition and its properties this alkaloid bears a marked resemblance to pelletierine, the active principle of pomegranate. Arecaline is an oily volatile liquid, with alkaline reaction, soluble in alcohol, ether, chloroform, and water. With acids it forms soluble salts.

*Areca* nuts are given in the form of powder; the dose is from a dram to a dram and a half. The alkaloid has not yet been administered with tenicide intent.

The rules for the administration of the *areca* powder are much the same as those given for the administration of pomegranate bark or pelletierine. Arecaline being a poison to the worm, benumbing and paralyzing

it for the time, the administration of the nuts must be followed by an active purge to remove the entire worm, before it has time to recover from its stupor. It is well to precede the ingestion of the remedy by milk diet, and by a purgative or enema the evening before, that the intestines may be cleared of fecal matters, and that the drug may have a better chance of coming in contact with the worm.

The helminth is generally expelled entire four or five hours after the ingestion of the remedy.

Another tenicide is the fruit of the well-known coconut, *Cocos nucifera*. For a long time the albumen of the coconut has been prescribed as a ténifuge in countries where the *Cocos nucifera* grows. Berenger-Terand, however, says that he has made trial of this remedy a great many times, and only once out of twenty-four succeeded in obtaining the expulsion of the head of the worm.

Pariso, of Athens, writes that while he resided in Abyssinia where it is the fashion to have tape-worms, he chanced to discover the tenicide properties of this albumen. On his return to Athens he tested it thoroughly, and always with satisfactory results, the whole worm being expelled dead.—*Boston Medical and Surgical Journal*.

**DANGERS OF NEPHRECTOMY FOR FLOATING KIDNEY.**—Many surgeons hold that removal of a movable or floating kidney is not justifiable. The amount of constitutional disturbance caused by the anomaly is, in their opinion, seldom so grave as to demand one of the most severe varieties of abdominal section. The opposite kidney may be diseased or even absent. The sudden removal of a displaced yet active and healthy kidney is also dangerous, because its fellow may not be able to take upon itself at once the functions hitherto discharged by two organs. The strain on the eliminating glands after a severe operation is great. Dr. Hager of Wandsbeck, has published a case illustrating this source of danger. The details are given in the *Berliner klin. Wochenschrift*. A floating right kidney was removed from a woman aged twenty-two, who suffered from anorexia, nausea, vomiting, debility, and occasional tonic and clonic convulsions. Bandages and belts were applied and kept on for a long time without any relief, therefore nephrectomy was performed. Within twenty-four hours of the operation free hemorrhage occurred, and the patient recovered but slowly from its effects. For a short time she began to improve in general health, but soon became steadily

worse. Dr. Hager discovered that the left kidney had become displaced. Renal calculi were passed occasionally. Nephrectomy was successfully performed; in the course of that operation the renal pelvis was examined, but no calculi could be felt. After convalescence, however, the patient grew worse, and remained subject to uremic symptoms. Dr. Hager considers nephrectomy unjustifiable, and believes that nephrorrhaphy is indicated in floating kidney. The method of doing the latter operation might yet be improved so as to give better results.—*British Medical Journal*.

**BROMIDE OF POTASSIUM AS AN ANTIDOTE TO IODOFORM.**—A case of resection of a carcinomatous rectum is referred to in the *Wiener Medizinische Blätter* for July 11, 1889, in which symptoms of poisoning were produced through the use of iodoform. Under the use of bromide of potassium rapid relief was obtained. This condition is explained by Samter and Retzlaff as due to the fact that bromide of potassium exceeds all other salts in its power for dissolving iodine compounds. They state that if a test tube be half filled with a solution of potassium bromide (1 to 3), fifty drops of tincture of iodine may be added without the iodine being displaced from its solution with the potassium bromide. This condition persists for several days, and bromide of potassium, of all the different salts recommended in iodoform-poisoning, is the only one which is capable of retaining the iodine in perfect solution.—*Therapeutic Gazette*.

**CERTAIN METHODS FOR DRESSING THE NAVEL-WOUND IN NEW-BORN INFANTS.**—Bearing in mind the experience of Liborius, Virchow, and others, concerning the antiseptic properties of the lime salts, Fagonski made use of a dressing of plaster of Paris for the navel stumps of one hundred new-born infants, the stumps having first been disinfected with a five-per-cent solution of carbolic acid. In a similar series of one hundred he used a stump dressing of salicylic acid and starch after Runge's method, of talc powder, and of absorbent cotton. The results are expressed in the following table:

	Plaster of Paris.	Talc.	Salicylic Acid or Starch.	Cotton.
Erosion of the navel region	4	5	2	3
Hemorrhage.....	7	10	8	4
Icterus.....	6	8	8	18
Ophthalmia neonatorum...	3	5	6	1
Periophthalmitis.....	2	48	51	29
Moist gangrene of cord.....	0	30	65	27
Mummification of cord.....	100	70	35	73
In days.....	2-3	5-6	5-6	4

The navel-cord stump in the first series fell usually on the fifth day, never later than the sixth; in the second series usually after the sixth day; in the third series also usually after the sixth day; the same was true for the fourth series. The requirements for a good dressing for the navel, that it should favor rapid and complete mummification of the stump, and hinder the entrance of pathogenic micro-organisms into the wound, are therefore best satisfied by the use of plaster of Paris, which acts antiseptically and hygroscopically.—*Archives Pediatrics*.

**PULSATILLA IN DYSMENORRHEA AND OVARALGIA.**—Dr. Charles Bovet states, in *Les nouveaux Remèdes*, No. 9, 1889, that he has successfully employed anemone pulsatilla in diseases of the uterus. He differs from other authors who ascribe the greatest activity to the tincture prepared from the dried plant, and states that he has found the latter preparation by no means as active as the alcoholic extract, made from plants gathered fresh in June, and composed of equal parts by weight of the plant and of ninety per cent alcohol. The glucoside obtained from the plant, and called anemonin, is less active than the extract. As regards the method of using the remedy: if the case is one of dysmenorrhea, Bovet gives the patient, four days before the beginning of the expected period, four tablespoonfuls of a wine which contains about ten drops of the alcoholic extract of pulsatilla to the tablespoonful. As soon as menstruation begins the use of the drug is discontinued for three or four days, and then resumed for three or four days in the dose employed at the beginning. Recovery from dysmenorrhea is frequently observed after following this practice for two months. If chlorosis exists along with dysmenorrhea, Bovet gives chloride of manganese also, in doses of five sixths of a grain to the tablespoonful of the wine of pulsatilla. In cases of ovaralgia, as the result of chronic infarct of the uterus or inflammation of the neighboring structures, the pulsatilla wine is given continuously, in moderate doses, until the pain completely disappears. Bovet states that complications are never observed in the course of the treatment.

As to the dose of anemonin: it was given in doses of from five sixths of a grain to one and one half grains a day, and never in a larger dose than three grains. It is decidedly more uncertain in its action than the alcoholic extract, probably because changes in its constitution take place when it is kept a long time.—*Medical and Surgical Reporter*.

**INTUBATION OF THE LARYNX; A NEW INSTRUMENT AS AN AID TO CERTAIN OPERATIONS.** (Thomas Annandale, British Med. Journal.) In operations involving the mouth and nasopharynx, in which bleeding may take place into the air passages and interfere with respiration, or in operations in which respiration is not satisfactory during the administration of an anesthetic, intubation of the trachea can, in most cases, be substituted for preliminary tracheotomy, and is a simpler and safer means of aid. As a means of restoring and carrying on respiration in cases of sudden obstruction in the larynx or trachea, intubation may also be substituted for tracheotomy. For these purposes the author successfully employed a gum-elastic catheter. Owing to certain disadvantages, he had constructed an elastic tube (not too pliable), having a slide of hard rubber which can be adjusted in any position to prevent compression by the teeth. To the end of the tube protruding from the mouth there can be attached a piece of tubing, through which an anesthetic may be administered if desired. For intubation in cases of acute inflammatory affections of the larynx, or for stenosis of the larynx, the result of chronic inflammatory conditions, or of accidental wounds, the author uses the tubes of Dr. O'Dwyer.—*Archives Pediatrics.*

**INTRA-CRANIAL HEMORRHAGE; OPERATION; RECOVERY.**—A boy, nine years old, was stunned by a fall from a cart. The symptoms were vomiting, photophobia, drowsiness, and mental irritation. There was no paralysis, and no fracture could be detected. On the fifth day convulsions set in, at first involving the right facial and supra-hyoid group of muscles. There were several convulsions on this and the following day. The muscles of the right upper extremity, the right sterno mastoid, and the diaphragm became involved during the attacks. He did not lose consciousness, but was aphasic. Sensation was perfect over all the affected parts—sure evidence that only the motor area was implicated. On the seventh day he was still aphasic, though conscious. Twitching of the muscles of the right side of the face and of the right fore-arm and hand persisted. That the pressure was due to extravasation of blood, and not to a depressed fragment of bone, was evinced by the fact that the symptoms did not occur directly after the fall. Abscess was excluded by absence of rise of temperature. The position of the fissure of Rolando was marked on the scalp by a line drawn from the ver-

tex at a point directly above the external auditory meatus to the depression just in front of it, and prolonged on the mesenteric region, so that during the operation there would be a guide to the fissure. A quantity of fluid and clotted blood was removed from beneath the dura. The patient improved, but there was a persistence of some of the symptoms; accordingly, the wound was again opened, and beneath the arachnoid a small quantity of dark fluid blood was found. Gradually speech and complete muscular power returned. The patient was discharged cured four weeks after the operation.—*Edward Owen, British Medical Journal.*

**THE URINE IN PERNICIOUS ANEMIA.**—Dr. William Hunter, of Cambridge University, England, who last year published some interesting and important observations regarding the symptomatology and pathology of pernicious anemia, has now supplemented these in the Practitioner, for September, by other observations on the urine in a case of this disease—observations which he thinks show that the urine in pernicious anemia presents specially characteristic features, and such as serve to establish the diagnosis of the disease.

A relatively high hemoglobin percentage to the number of red blood corpuscles Dr. Hunter considers to be the only characteristic feature presented by the blood in pernicious anemia, but he is of those who regard pernicious anemia as a distinct and separate disease, not merely as an extreme form of anemia or chlorosis or the terminal stage of other diseases.

In the case under observation the color of the urine was the most striking feature throughout. It was exceedingly high, varying slightly from time to time, but always remaining very much higher than ever observed in conditions of health. At no time were any bile pigments to be detected. As regards its spectrum and its chemical behavior, the coloring matter present in such large quantities had all the characteristics of pathological urobilin; and there is no doubt that in all cases such urobilin is a product derived from the disintegration of hemoglobin. The richness of the patient's urine in coloring matters could have had absolutely no relation to the absorption of matters derived from the food, as this was as little nitrogenous as possible, and consisted mainly of milk. The excretion of such large quantities of coloring matter, entirely independent of the occurrence of fever or of any diminution in the quantity

of urine or rise in the specific gravity, was regarded by this observer as of the greatest interest and importance in its bearing on the diagnosis of the disease; and Dr. Hunter is disposed to maintain that the excretion of such large quantities of pathological urobilin appears extremely valuable evidence as to the essential nature of the disease, that it depends on an excessive destruction of blood, that it is hemolytic in its nature.

In his former observations, his conclusions regarding the hemolytic nature of this disease were based solely on (1) a consideration of anatomical changes to be found after death, and (2) on the possibility of inducing experimentally similar changes in animals by the action of blood-destroying agents.—*Boston Medical and Surgical Journal*.

**TUBERCULOSIS AND TABES MESENTERICA.**—A careful analysis of one hundred and twenty-seven cases of fatal tuberculosis in children by Woodhead showed that the disease selects particular organs, by preference, as it were, at different periods of life. In the tabulated series it appeared that the intestinal canal was involved in only forty three of the one hundred and twenty-seven cases, while the mesenteric glands were involved in one hundred, of which sixty-two occurred between the ages of one and five and a half. The most common cause of primary localization of tuberculosis in the mesenteric glands was thought to be the use of milk containing the tubercle bacillus. Most of the cases in the table were breast-fed during the first year of life, and there were few deaths during that period, tuberculous mastitis in adults being a very rare affection. Tuberculous mastitis in children is, however, quite common, and it is probably due to the fact that so much tuberculous cow's milk is used as food for children between the ages of two and five. In addition, the great functional activity of the glands at this period of rapid growth may produce an exhausted condition of those glands which renders them less competent to resist the influence of the tubercle bacillus than at other times. In addition to the analysis referred to, the author investigated the condition of six hundred cows in the stables of Edinburgh. Among them were found thirty-seven which had tuberculous mastitis, but in the milk of only six of these could the tubercle bacillus be found. The tissues of the diseased organs were, however, abundantly supplied with tubercle bacilli and giant cells. The disease was widely disseminated in the course of the inter-lobular lymph tract.

Granulations abounded in the lumen of the milk-ducts; then followed ulceration, and thence the tubercle bacilli readily found their way into the milk.—*Archives Pediatrics*.

**SULFONAL FOR NIGHT-SWEATS.**—Although the number of remedies recommended for night-sweats is very large, it may not be amiss to give some information regarding a new cure, sulfonal, the soporific recently so warmly recommended. Bättrich's attention was first attracted to the subject by the case of a lady eighty years old, to whom he had administered only one quarter gram as a soporific. The lady had been suffering with night-sweats so profuse that her clothes were changed twice every night. After taking this powder, she asked him whether he had mixed any thing for those sweats in it. Further experiments showed that in most cases night-sweats could be prevented by one half gram of sulfonal. He considered the effect of sulfonal similar to that of atropin, but it is wholly free from unfavorable side-effects. Moreover its effect is lasting, the sweats of the second night being much less profuse without sulfonal.—*Brooklyn Medical Journal*.

**EXCISION OF A LARGE NEVUS.**—(Edmund Owen.) The nevus, the size and shape of a Tangerine orange, was situated over the right pectoral region of a child two months old. The skin on the surface was red in color, and the blood could be squeezed out on firm pressure. It was removed by excision, being attacked in sections, and the bleeding vessels secured as soon as divided. Very little blood was lost. The edges of the incision were brought together by deep wire sutures. Healing was complete in sixteen days. The author believed that if transfixion and ligature had been employed the infant would have sunk exhausted by pain and suppuration, while the deepest parts of the mass would not have been reached. Electrolysis would have required at least three operations.

In removing a nevus by the scalpel, it is necessary to keep well beyond the nodules of vascular fat which surround the spongy and growing mass. With plenty of catch-forceps the whole tumor can be cleanly removed without hemorrhage.—*Archives Pediatrics*.

**A METHOD OF OPENING THE ANTRUM OF HIGHMORE.**—(Ziem., *Therapeutische Monatshefte*, 1888, April and March, pp. 148 and 222). Z. found the most useful instrument for opening the cavity of the antrum to be the so-called American boring machine or surgical engine

used by dentists. The instrument usually employed is a drill of one and a quarter millimeters; larger ones can be used. Z. prefers to enter from the intermediate space between the second bicuspid and first molar tooth, or between the two bicuspid teeth. Z. claims that the opening of the antrum with this instrument is easy and safe, even in cases of uncertain diagnosis, where an exploratory puncture is to be made. He also claims that this method is less dangerous, easier and more certain than the method of Mikulicz's, of operating from the nose.—*Brooklyn Medical Journal*.

**ACUTE INTUSSUSCEPTION IN A CHILD CURED BY OPERATION.**—(Thomas Annandale.) The author records this case in order to emphasize the importance of early operation in cases of acute intestinal obstruction when other means have failed to relieve the condition. In this case enemata and the introduction of a bougie failed to relieve, although very gentle traction from within, after the abdomen had been opened, was sufficient to release the invagination. The author calls attention in this paper to the additional proof afforded by this case of the value of traction upon intestines from within in certain cases of strangulated hernia, or some other forms of intestinal obstruction. The child, aged three years, had suffered for two days with the following symptoms: Pain in abdomen with vomiting; passage of several ounces of blood per rectum; and upon the left side, toward the lumbar region, an elongated swelling was felt. Examination per rectum discovered a mass on the left side that could be pushed up, but would immediately descend. The abdomen was opened by a central incision about two inches in length. The intussusception was relieved at once by slight traction. Immediately wind was passed freely by the rectum. The child made a perfect recovery.—*Archives Pediatrics*.

**THE LUNGS AND LIVER IN PHTHISIS.**—Dr. Pleshivtseff (*St. Petersburg Dissertations*, 1888-89, No. 85) has weighed and measured the lungs and liver in eighty cases, forty-eight of which had died of phthisis. These weights and measurements are, in the tables he gives, all reduced by calculation to a common standard of height, viz., 100 centimeters. Thus, in the body of a woman 150 centimeters in length, all the weights and measurements are reduced to two thirds of their actual value. In this way a fair comparison may be made between bodies of different sexes and sizes. The total volume of the lungs in phthisical subjects was found

to bear to that of non phthisical subjects the ratio of 2,414.8-2,107.5; the volume of the liver in the two classes of cases had a ratio of 1,404-1,270. The lumen of the aorta was greater in the phthisical cases than in the others in the proportion of 65-79, and the circumference of the bronchi in the proportion of 70.8-81.1. Another table gives the ratio of the circumference of the bronchi and pulmonary artery to the volume of the lungs, and of the circumference of the portal vein and of the hepatic artery to the volume of the liver. The mean results obtained were, that in the phthisical cases the bronchi were  $\frac{1}{25}$  and the pulmonary artery  $\frac{1}{34}$  of the lung volume. (The one measurement is linear, the other cubic, but this does not affect the comparison which the author wishes to draw.) In the non-phthisical cases the fractions were  $\frac{1}{25}$  and  $\frac{1}{19}$  respectively. The mean circumference of the portal vein was  $\frac{1}{12}$  of the volume of the liver in the phthisis cases and  $\frac{1}{10}$  in the others. The hepatic artery was also relatively smaller in the phthisis cases, being  $\frac{1}{16}$  in them and  $\frac{1}{12}$  of the volume of the liver in the others.—*London Lancet*.

**PEPSINUM PURUM TABLETS, SUGAR COATED.** These tablets are readily soluble, are without admixture of foreign substances, and will retain their activity indefinitely. Parke, Davis & Co. have given especial attention to digestive ferments, and their pepsin and pancreatin products have been proven of superior activity to all others, both by elaborate comparative tests by eminent chemists and by clinical practice. These tablets furnish a very convenient form for administration of this now popular remedy.

**THE TREATMENT OF HYDATID DISEASE OF THE LIVER.**—Dr. Davies Thomas, whose contributions to the study of hydatid disease have been numerous and important, sums up the results of his researches (*Australian Medical Journal*, June 15th) as follows: That there is reason to believe that tapping operations fail to cure the patient in fully forty per cent (or more) of the cases in which they have been tried; and that, taking aspiratory puncture and ordinary tapping operations together, the deaths amounted to nearly eighteen per cent, but the mortality following aspiratory puncture was only about half that of punctures with an ordinary fine trocar. Speaking generally, the greater the number of punctures required in a given case the smaller is the probability of cure by tapping alone. Simile puncture, though generally devoid of risk, has been

known to cause sudden death, sometimes from shock, sometimes, in the case of pulmonary hydatids, from suffocation by the fluid contents of the bladder-worm. As to parasiticide injections and the use of electrolysis, there is no evidence in their favor that does not apply to simple puncture, while each has drawbacks of its own. The mortality of the various forms of radical operation is given as follows:

Caustics, 33.68 per cent; *canule à demeure* 26.66 per cent; Simon's method 48.0 per cent; Volkmann's method, 19.05 per cent; Lindemann's method (abdominal section), 10.29 per cent, and ditto (thoracic incisions) 29.41 per cent. From which it appears that abdominal section yields an even lower mortality than puncture of the cyst.—*London Lancet*.

**SALIX NIGRA.**—This remedy has been used with much success as a sexual sedative in the treatment of masturbation, excessive venery, spermatorrhea, and ovarian disease. As a sexual sedative the fluid extract of the buds is considered the most efficient. Dose,  $\frac{1}{4}$  to 1 fluid dram, not miscible with water. As a general tonic and antiperiodic the fluid extract of the bark is employed with advantage. Parke, Davis & Co. make both these extracts, and will mail to the medical profession, on demand, working bulletin giving botanical description, medicinal activity, use, and notes of cases.

**ABDOMINAL SECTION IN TYPHOID FEVER.** At a meeting of the Royal Academy of Medicine, in Ireland, May 17, 1889, Dr. J. H. Nicholas read a paper on abdominal section in typhoid fever. The histories of two cases were read and specimens shown for the purpose of inquiring whether or not opening the abdomen is justifiable in perforation of the intestine in typhoid fever. It was assumed that the existence of diffused acute peritonitis might be accepted as a diagnosis of perforation existing; and as recovery, with fecal matter exuded into the cavity of the abdomen was absolutely impossible, it was suggested that before collapse appeared the abdomen might be opened and washed out, and the opening sewed to the anterior wall. Among the many objections the following were mentioned: difficulty of diagnosis; condition of the patient; difficulty of finding the perforation; diseased condition of the wall of the gut; many cases diagnosed as perforation having recovered. The author endeavored to answer these objections.

Dr. Ball said the treatment of perforating ulcers from typhoid fever by abdominal sec-

tion had been adopted on several occasions with results uniformly fatal; that such a result was to be expected was due to the fact that the union of intestinal wounds demanded not only a very accurate adjustment, but a very rapid healing of the parts.—*British Medical Journal*.

**A CASE OF DYSENTERY TREATED BY INJECTIONS OF SULPHATE OF COPPER.**—The case narrated in the *Lancet* of August 31st by Mr. Hepburn reminds me of a case where injections of sulphate of copper were most successful. The patient, J. O., aged fifty, was a thin, spare man. He lived in the Cambridgeshire Fens, and in his young days had suffered from ague. The water supply to his house was very bad; the usual drinking-water was rain-water kept in a wooden tub, and when this ran short that from the dykes was used. I first saw him on December 31, 1876; he had all the symptoms of a smart attack of dysentery; these continued for a week, when he was much better. On January 14, 1877, he had a relapse, but improved by the 20th. On the 21st I heard he was worse, and was passing a lot of blood, and had much tenesmus. I at once prepared an injection of sulphate of copper, 10 gr., tincture of opium, 1 dr., and four ounces of water. On reaching the house I found him lying in a small pool of blood. He informed me this had been going on all night, and the tenesmus was unbearable, bringing away blood and mucus. I well oiled a large, long gum-elastic catheter, and with a finger in the rectum passed it as far into the bowel as it would go, which was at least fifteen inches; through this the copper solution was injected from a small brass syringe; it caused no pain; and in the evening the tenesmus was relieved, and very little blood had passed. On the 22d he was decidedly better, but more blood in the stools than I liked, so the injection was repeated, and again on the 23d; and from this date he recovered rapidly. My treatment prior to the copper injection was bismuth, gallic acid, a full dose of powdered ipecacuanha; but nothing gave such rapid and permanent relief as the copper and opium. The diet was purely milk. I have not had such a bad case as this in an adult since, but in children several, and here the same treatment proved successful.—*W. Easty, M. D., London Lancet*.

**GLYCERINE OF BORAX IN THE DIARRHEA OF INFANTS.**—If we regard infantile diarrhea as due to the excessive fermentation of food in the intestinal canal causing irritation and a catarrhal condition of the intestinal mucous

membrane, it seems reasonable to look for a remedy to act both on the cause and effect. Glycerine itself is an antiseptic of no mean order, and relieves the congestion and pain of inflamed piles, chiefly mucous surfaces, while every mother knows the virtues of glycerine of borax when applied to the mucous membrane of the mouth. So it was no great step to introduce it further into the alimentary canal. Whether fed from the breast or brought up by hand, the motions of patients with diarrhea infantum were like curds of milk, suggesting that the irritated intestine had hurried its contents on as quickly as possible. Again, they were very foul-smelling, suggesting great fermentation. Therefore the glycerine of borax has to do two things: to act as an antiseptic to prevent excess of fermentation in the stomach and intestines, and to soothe the mucous membrane thereof in passing over it. I have found it answer capably; the children like it, it lessens the griping pains, it renders sweet the offensive motions, and it stops the diarrhea. One case died while under this treatment; the child was seven months old, had had diarrhea two days, and was utterly worn out when I saw it. But I suppose there always will be cases which come under our notice too late for cure. I give it as follows: Glycerine of borax, twenty minims; tincture of orange, three minims; distilled water to one dram. To be given every one, two, or three hours, according to the severity of the case or the age of the patient.—*Dr. E. Mansel Simpson, Ibid.*

**SOME PRACTICAL POINTS IN THE DIAGNOSIS OF MALARIA IN CHILDREN.**—*Dr. H. N. Vineberg*, New York, read a paper on this subject before the American Society of Pediatrics. The paper was based upon a study of eighty cases of malaria occurring in early life. The symptoms of the affection are chill, fever, sweating, enlargement of the spleen, and the presence of hematozoa.

Chill is rare in young children, and may be replaced by convulsions, which may be repeated several times in a few hours. There is one disease in particular which makes a child very prone to convulsions, that is rickets. This is true of the mild as well as of the severe forms of the affection.

Fever is a most constant symptom. It is said to be distinguished from the fever of other affections by its violence and rapid disappearance. Sudden onset of high temperature may also occur in other affections.

The sweating stage in children is usually imperfect, both in degree and duration.

The spleen enlarges more rapidly and to

a greater degree in children than in adults. In early life, even small doses of the poison are sufficient to cause an increase in the size. While, at first, it decreases in size with the subsidence of the paroxysm, yet after two or three paroxysms it remains enlarged in the intermission. Splenic enlargement is, however, not a pathognomonic sign of malaria. All of the acute infectious diseases are attended with swelling of the spleen.

**Hematozoa.** The diagnostic importance of this sign is still in doubt, although the weight of evidence is in favor of their pathognomonic value. They appear to be present only in the grave types. The author had sought for them in fifteen cases of acute malarial poisoning, but had not found them.

The diseases most likely to be mistaken for malaria are acute gastritis and typhoid fever. Swelling of the spleen is, however, absent in acute gastritis, although present in typhoid fever. Some lay great store on the negative value of herpes labialis. While common in acute malaria, it is said to be absent in typhoid fever. The temperature range in typhoid fever is different from that of malaria. The appearance of a roseola rash in typhoid fever is pathognomonic; but for this we have to wait twelve days. If still in doubt, the blood should be examined. In such cases quinine is of value as a therapeutic test.

In the cases of chronic malaria, enlargement of the spleen becomes of great importance as a diagnostic sign.

**BACTERIA AND VIRUS.**—The connection between bacteria and disease is not explained by the simple fact of the invariable presence of certain microbes of certain diseases, nor by the circumstances that such diseases can be reproduced in animals by inoculations with these microbes. The bacterial theory of disease, like that of fermentation, involves a far larger question. It implies that these parasites are capable of converting the media in which they flourish into chemical substances that have a poisonous action on the body, deranging its normal mechanism and thereby producing various groups of symptoms, and even death. It is well known how of late years attention has been gradually becoming fixed upon the chemical aspect of morbid processes, and there has also been a growing belief in the necessary intervention of bacterial "ferments" to produce the alkaloidal substances known as ptomaines, which are derived from the albuminoid elements, and to

which so much has been attributed. Dr. Brieger, whose name is largely associated with this subject, reviewed it in its general bearings in an address delivered at the recent meeting of German naturalists and physicians at Heidelberg. He pointed out (*Berl. Klin. Woch.*, No. 39) how the domain of "infective" disease was widening at the expense of diseases due to nutritional and nervous changes, and proceeded to show that whereas in nature we have everywhere abundant evidence of bacterial chemistry, so in disease analogous effects due to the agency of these minute organisms are to be observed. That the normal vital processes are accompanied by the production of a large number of substances of the aromatic series, such as skatol, indol, carbolic acid, etc., was pointed out by Mischelich and Hoppe-Seyler; and these products of putrefaction were to be found in the living body or its excreta in greatest amount when the vital powers were much impaired. But these substances are of far less importance than the basic products of bacterial life, which Brieger distinguishes into the highly poisonous toxine and the non-poisonous ptomaine; the latter, it may be remembered, having been first discovered by Selmi in the cadaver. Toxine (using the term in a generic sense), he showed, is produced even in the primary act of digestion, for peptones injected under the skin of animals often produce symptoms of poisoning; and the action of pepsin or fibrin produces a poison that causes paralysis and even death in some animals. The number of similar products formed in the further course of digestion is very large; the most poisonous of such derivatives is of albuminoid disintegration being neurin (derived from cholin) and methylguanidin (from creatin). The poisonous effects of certain articles of diet (all the cases of mussel-poisoning, sausage-poisoning, etc.) are to be attributed to like principles due to bacterial ferments. Dr. Brieger then showed that up to a certain point various forms of toxine had been obtained from pathogenic bacteria—as the staphylococcus aureus, streptococcus pyogenes, typhoid bacillus (typhotoxin), cholera bacillus, anthrax bacillus, tetanus bacillus, and others, and then referred to the subject of auto-intoxication, which has been so well studied by Bouchard and Gautier. It was shown that there was a parallelism between the fermentations excited by pathogenic bacteria and those of putrefactive organisms, and that a disease (for example, typhoid or tetanus) owes its specific characters to the special toxine thereby pro-

duced. A further development of the subject lies in the explanation of immunity, and the idea that the products of one kind of microbe may neutralize or destroy the effects of other toxins. Infection thus comes to be really an "intoxication," and the susceptibility to infection to depend on the greater or less tolerance of the body to the poison. The whole facts of protective inoculation accord with this view, so that it may be expected that in time immunity may be obtained through the agency of the ptomaine and toxine of the disease concerned. Then, said Dr. Brieger, will the therapeutic aims of medicine—the establishment of rational and therefore of specific measures of cure—be attained, and this can only be by a close connection being formed between pathology and chemistry.—*London Lancet*.

TREATMENT OF PRURITUS VULVÆ.—Dr. Percy Newell recommends the following lotion for pruritus vulvæ:

Acid carbolicæ .....	gr. xvi;
Tr. opii.....	f 3ss;
Acid hydrocyan dilut.....	f ʒii;
Glycerini.....	f 3ss;
Aquæ destil. q. s. ad.....	f ʒiv.

M. Ft. lotio.

Dr. Scanlan recommends the following:

Cocain.....	gr. i;
Lanolin.....	ʒi.

M. Ft. unguentum.

CORNUA CUTANEA.—Horns growing from the skin are considered somewhat uncommon; the following case came recently under my observation in a laboring man of sixty-five years: The horn projected for an inch from the lower lip on the right side; it had a blunt extremity, was firmly adherent, and the skin around at the base superficially ulcerated. He stated that it had first appeared as a small warty growth three years ago, had slowly increased, and after being cut off with a razor on two occasions seemed to grow again quicker each time. On the opposite side of the same lip was what appeared to be another warty growth in its early stages. He was in the habit of holding his clay pipe this side, and not on that from which the horn grew. There were no glands enlarged, and the patient was in good health. The treatment consisted in removing the horn, together with the part of the lip that it was attached to, by a small V-shaped incision under cocaine locally injected, and bringing the edges together with one or two sutures. *H. H. Fisher, London Lancet*.

# The American Practitioner and News

"NEC TENUI PENNĀ."

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D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } - - - Editors.

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## WHAT HAS BECOME OF THE ELIXIR VITÆ?

Of all the ill-fated crafts which within a decade have been launched upon the sea of medicine under the banner of a great name, none has made more stir than the alleged discovery of Brown-Séquard, nor has any run a quicker course. The newspapers and the quacks made it odious before the sober-minded members of the profession had opportunity to test its worth or worthlessness. The medical editors, almost without exception, gave it unqualified condemnation, while such physicians as tried it did so under protest, and without that expansive expectancy which gives hope to the patient and insures that attention to details so necessary to the successful carrying out of any complicated therapeutic measure.

Be it as it may, the only results noted were abscesses, septicemia, and a few very ridiculous and brief senile capers. The great restorer of youth to the aged died a natural death, while its great discoverer was commiserated for the loss of mental power by the charitable, and laughed at for a drivelling dotard by the uncharitable. It would seem, however, that in the treatment of the

alleged discovery the profession has probably been too prompt to condemn, and that it might have been more graceful and respectful, and certainly more scientific, to have given it more serious attention.

That there is a germ of truth in the apparently absurd claims of Brown-Séquard would seem to be attested by the following item, which is just now going the rounds in the medical press. *Spermine* is an alkaloid found in the *testicular juice*, in the gray matter of the brain, in eggs, cysters, lampreys, fish ova and milt, also in the products of all atonic mucous membranes. It also appears in the sputa of senile and acute bronchitis, in the expectoration of phthisis, and of emphysema with catarrh, and in the spleen and circulation of anemias and of leucocythemias. The *hydrochlorate of spermine*, in a dose of one fortieth of a grain, injected subcutaneously in a dog of thirteen pounds, produced marked mental and physical activity, and powerful and prolonged stimulation of the genital system."

We don't know the age of this item, as we have not seen the original article from which it was culled, but take it to be a recent physiologico-chemical investigation proving the competency of testicular juice to supply to the devitalized a vitalizing compound which, if the alkaloid can be isolated in a pure state, may prove to be a therapeutic agent of real stimulant or constructive force and of easy administration.

At any rate, it begins to look as if the great Franco-American physiologist was about to turn the laugh on those who have been in too great a hurry to laugh at him.

MEDICAL HERALD—Mr. J. H. Fowler, who for several years has edited the pharmaceutical department of the our esteemed contemporary, announces in the November issue his retirement from the work. We commiserate the Herald upon the loss from its staff of an industrious worker and graceful writer.

## Notes and Queries.

NEW YORK LETTER.—To one in search of surgical entertainment, New York City offers the theater of almost unlimited opportunity; not a great quantity of trifling and comparatively uninteresting steps, but abundance of rare and classical operative procedures, accomplished with the courage and authority of the master. Extensive field and acknowledged reputation make the New York surgeon an autocrat in his profession. Standing by the peculiar surroundings almost beyond criticism, and strengthened by an experience limited only by his choice, he proceeds with his knife and needle, unrestrained by any limit but his judgment, to attain every thing possible to human skill and endurance.

My preconceived impressions of these gentlemen were errors. I expected to see dash and brilliancy in operative steps, but I am sure I can pay no higher compliment to their integrity of purpose than to say I have detected no record-maker among them all. Perhaps the acme of brilliancy is satisfactory results. Surely it is results to which the surgical steps I have witnessed were directed. A New York clinic is a matter of from two to four hours, as the occasion may require, and there is never any hurry.

Through the medium of letters kindly furnished me by Drs. Vance, Palmer, Mathews, Wathen, and others, of Louisville, I obtained a place by the operating table of such men as McBurney, Wyeth, Dennis, Bull, Gerster, Sims, Wylie, etc. In a few words, I would characterize these operators as accurate in judgment, conscientious in advice, rigid in antiseptic cleanliness without exception, and, beyond all, as patient and careful almost to the danger of tediousness in operation.

At the Roosevelt Hospital I saw McBurney spend an hour and a half in an operation for strangulated hernia, and the establishment of an intestinal anastomosis. Though he appreciated the importance of time, yet he valued accuracy even more. The Albe catgut rings were used. The patient reacted well.

At the same clinic he did on another patient his radical cure, open method for inguinal hernia, dissecting out the sac through a wound extending up to the internal ring, tying off the sac with catgut as high as reach can go, stitching the edges of the skin to the far margin of the wound in the aponeurotic tissues, and allowing the open wound to granulate.

At the Polyclinic Hospital Wyeth deliberately dissected out the great sciatic nerve from the upper third of the thigh to the popliteal space, found the separated parts of the nerve, which had been divided by a shot wound months before at the point of division into the peroneal and internal popliteal, causing a total paralysis. About two inches of separation existed, which was increased after resection of the ends to three or more. The two branches were then stitched to the trunk with catgut, and the leg fully flexed on the thigh.

At the Mount Sinai, after a rather tedious effort, Gerster succeeded in splitting the *tunica propria* and pulling out the greater portion of the kidney, which he tied off as well away from the pyramides as he could get, and removed for a pyo-nephrosis with firm adhesions. The wound was closed around a drainage-tube. The condition of the other kidney was not known.

Space is left me to mention but one other of the many unusual operations I have witnessed. At the New York, Bull operated on a large bronchocele, dissecting the gland away with great patience and skill, successively tying the *thyro-hyoid* arteries on each side, and finally removing the entire gland except a small portion of the left lobe, which he was unable to separate from its attachments. It was his original intention to leave a portion of the gland to avoid the dangers of myxedema.

Great care is paid to surgical principles by all operators. Hemorrhage, shock, exposure to cold, are all reduced to the minimum, and thorough cleanliness and perfect asepsis or antisepsis are observed in all cases. The anesthetic is, in almost all cases, ether. Wyeth uses chloroform occasionally for

children. In all plastic operations on the face I have seen Wyeth use ether by the rectum, and he tells me he is constantly doing so with great satisfaction.

H. H. GRANT.

OCTOBER 22, 1889.

**MEDICAL SUCCESS IN THE FACE OF DIFFICULTIES.**—Sir Andrew Clark, from the summit of English professional success, has been reviewing the way which led him, and his reflections, as contained in an address made by him on the occasion of the presentation to him of his portrait by the medical and surgical staff of the London Hospital a few weeks since, can not fail of interest for all medical readers.

He was born in Scotland, and received his early education at Aberdeen. He went to London at the end of the year 1853 to study pathology, but with no intention whatever of engaging in the practice of medicine. He says he had never seen his parents, for they died in his infancy; he had never lived under the roof a relative; he had only one acquaintance; he had no introductions, and he was in such poor health that, according to a physician whom he consulted at the time, his expectation of life was only one year. On the other hand, he tells us that he had some advantages by way of counterbalance. These were a small patrimony, large love of work, and perfect self-dependence, which prevented him from ever asking favors of any man. "I had the habit of dealing with every day of my life as if it were my whole life," he says. "I was contented and happy over what the day brought me. I had no ambition of any kind, and I hated schemes and intrigues."

His first employment at the London Hospital was in the museum of that institution. After he had been there a while a vacancy occurred on the staff, and he became a candidate for the appointment, being warmly supported by his colleagues and the medical students. There were other candidates for the place, and the contest was a severe one. "It was the greatest fight," says Sir Andrew Clark, "that had ever been fought at a London hospital, and I well remember, when the fight was over, how one of the

opposing parties said: 'Poor Scotch beggar! let him have it, he can not by any possibility have six months to live!' But the race is not to the swift, nor the battle to the strong. I am still living and working among you to-day, the sole representative of the staff of thirty five years ago."

After frankly saying that he never expected to achieve the material success he has met with, Sir Andrew Clark said he presumed some of the students present would like to know from him what conditions he thought were essential to make a man a successful physician. These he gave as follows:

"Firstly, I believe that every man's success is within himself, and must come out of himself. No true, abiding, and just success can come to any man in any other way. Secondly, a man must be seriously in earnest. He must act with singleness of heart and in earnest; he must do with all his might and with all his concentration of thought the one thing at the one time which he is called upon to do. And if some of my young friends should say here, 'I can not do that. I can not love work,' then I answer that there is a certain remedy, and it is work. Work in spite of yourself, and make the habit of work, and when the habit of work is formed it will be transfigured into the love of work; and at last you will not only abhor idleness but you will have no happiness out of the work, which then you are constrained from love to do. Thirdly, the man must be charitable, not censorious, self-effacing, not self-seeking; and he must try at once to think and to do the best for his rivals and antagonists that can be done. Fourthly, the man must believe that labor is life, that successful labor is life and gladness, and that successful labor, with high aims and just objects, will bring to him the fullest, truest, and happiest life that can be lived upon the earth"—*Boston Medical and Surgical Journal*.

SIR HENRY ROSCOE, M. P., delivered an address at Birmingham this week, as president of the Midland Institute, taking for his subject the "The Life work of M. Pasteur,"

whose discoveries, he said, had culminated in the cure of that most dreaded and fearful of all maladies, hydrophobia. This was not the result of a happy chance, but the last link in a long chain of discoveries, including the exterminating of cholera, of cattle disease, and of splenic fever. Thus to M. Pasteur we owed the science of bacteriology, which dealt with the minute organisms called microbes, and which bids fair to revolutionize the theory and practice of medicine.—*London Lancet*, October 12, 1889.

**GUNPOWDER AS A MEANS OF CRIMINAL ABORTION.**—Dr. Alexander I. Voitzekhovsky describes (Proceedings of the Elisavetgrad Medical Society, September 20, 1888) two curious cases of criminal abortion caused by the infernal use of gunpowder, in the dose of a small-sized wineglassful. In both of the women, who were peasants, the fetus was expelled in a few hours after the ingestion of a single dose. The substance seems to enjoy the reputation of a reliable emmenagogue and ecboic in Russian popular medicine. As Dr. Voitzekhovsky thinks, it acts identically as savine oil, rue, powerful drastics, and such like ecboic drugs, which give rise to abortion through their causing primary toxic gastro-enteritis. The most energetic ingredients of gunpowder are said to be nitrate of potassium and sulphur. The author also mentions a case of abortion, at the second month of pregnancy, in a woman who used for the purpose large quantities of the so-called *glühwein* (Russian *glintvein*); that is, a red wine mulled with such spices as cloves, cinnamon, pepper, etc.—*Medical and Surgical Reporter*.

THE annual meeting of the *Southern Surgical and Gynecological Association* will be held in the Senate Chamber, Nashville, Tenn., November 12, 13, and 14, 1889. President, Hunter McGuire, M. D., Richmond, Va.; Vice-Presidents, W. O. Roberts, M. D., Louisville, Ky., Bedford Brown, M. D., Alexandria, Va.; Secretary, W. E. B. Davis, M. D., Birmingham, Ala.; Treasurer, Hardin P. Cochrane, M. D., Birmingham,

Ala.; Judicial Council, John S. Cain, M. D., Nashville, Tenn., W. T. Briggs, M. D., Nashville, Tenn., J. M. Taylor, M. D., Corinth, Miss., DeSaussure Ford, M. D., Augusta, Ga., Virgil O. Hardon, M. D., Atlanta, Ga.; Committee of Arrangements, J. R. Buist, M. D., Duncan Eve, M. D., Richard Douglas, M. D., J. H. Blanks, M. D., W. T. Briggs, M. D. The programme, which is very large, appeared in our issue of September 12th.

AN epidemic of typhoid fever recently broke out in the New York Central car shops at West Albany, N. Y., and by September 24th there had been eight deaths, and about three hundred men were prostrated by the disease or kept at home by the sickness of some member of their families. The outbreak was caused, according to one account, by drinking water from wells poisoned by the drainage from outhouses; according to another the danger lies in the fact that a portion of the infected district drains into an old reservoir which is still used by the lower portion of the city, and the foul condition of which was the cause of the efforts two years ago to obtain a new supply of water for the city. In one large shop, employing several hundred men who have used the city service water, not a case of sickness has occurred.—*Medical and Surgical Reporter*.

THE ratio of illegitimate births in the various countries of Europe is, according to the last reports, as follows: Out of every hundred births, seven were illegitimate among the Spanish, eleven among the Italians, sixteen among the English, and twenty-four among the Germans. In Paris, however, the illegitimate births reached thirty-eight among people of French nativity.

CHAS. CHADWICK, Ottis R. Wyeth, Louis Schoen, Geo. J. Schoen, Chas. F. Herrmann, Geo. Eyssell, and Horace L. Roy, druggists, of this city, were brought before Judge Worthen, to-day, and each fined \$500 and costs for counterfeiting a trade-mark preparation, known as Bromidia.

KANSAS CITY, MO., October 28, 1889.

**LEPER COLONY.**—The leper colony on the Sandwich Islands contained a hundred persons in 1884. At present the number is smaller, and most of them are men. The government, according to recent reports, contributes \$100,000 a year toward the expenses of the colony, and three years ago the king personally inspected it. The average duration of the disease is eleven years, and the mortality fifty-eight per thousand. The local physician, Dr. Hoffman, is a victim of the disease.

It is reported from Portsmouth, N. H., that Dr. H. F. Bradbury, who has figured conspicuously in connection with the bogus medical colleges in Vermont, New Hampshire, and Massachusetts, was arrested in Norway, Maine, October 3d, and brought to Portsmouth, where he was arraigned before the United States Commissioner, charged with fraudulent use of the mails. The Commissioner held him in \$10,000 for the Circuit Court at Concord, October 8th.

**TREATMENT OF CATARRH OF THE BLADDER.** Dr. L. Frey, of Vienna, strongly recommends the treatment of chronic catarrh of the bladder with thorough irrigation with warm water, followed by injection of a pint of lukewarm water to which has been added a tablespoonful of the following mixture (*Weiner med. Presse*):

Iodoform .....	5 ounces;
Glycerine.....	4 fl. ounces;
Distilled water.....	1 fl. ounce;
Gum tragacanth.....	12 grains.

**SURGEON-GENERAL HAMILTON**, of the Marine Hospital Service, has been authorized by the President to keep open the quarantine stations at Delaware Breakwater, Tortugas Keys, Sapelo Sound, and Cape Charles.

A CONTRIBUTOR to the British Medical Journal tells of the birth of twins, each of which had been strangled *in utero* by the umbilical cord of the other wound around its neck so tightly as to be sunk deeply into the flesh.

**OVARIOTOMY DURING PREGNANCY.**—In the *Gaceta Medica*, August 15, 1889, Dr. T. Noriega, of the City of Mexico, gives an interesting account of a case in which he did a successful ovariectomy upon a pregnant woman. The patient was twenty-four years old, and in the fifth month of pregnancy.

The account is very complete and accurate, and is illustrated with a beautiful woodcut.—*Medical and Surgical Reporter*.

**IMPORTANT TO DOCTORS.**—It is stated that a Paris stationer has invented an ink warranted to fade off the paper in a week without leaving the slightest trace. To say nothing of the advantages of such a discovery to fickle lovers and shifty politicians, the use of this convenient liquid may perhaps commend itself to medical practitioners who have strong opinions on the question of vested interests in prescriptions.—*Maryland Medical Journal*.

**MISSISSIPPI VALLEY MEDICAL ASSOCIATION.** It is the wish of the undersigned, so far as possible, to make a collection of all the papers, etc., presented at the various meetings of the Mississippi Valley Medical Association. Gentlemen having reprints, or journals containing such matter, will confer a favor by sending it to E. S. McKee, M. D., Secretary, 57 West Seventh Street, Cincinnati.

**NASHVILLE PRISON CONGRESS.**—The Annual Congress of the National Prison Association of the United States will convene in the Senate chamber of the Capitol at Nashville, Tennessee, at 10 A. M. Saturday, November 16th, and will continue its session until the evening of Wednesday, November 20th.

**THE GERMAN DERMATOLOGICAL SOCIETY.**—The next annual meeting of this Society will be held at Berlin in connection with the International Medical Congress. Professor Caspari, of Königsberg, has been appointed president; Professor Neisser, of Breslau, secretary, and Professor Lipp, of Graz, treasurer, for the year 1889-90.

**EDUCATIONAL GARDENS.**—School gardens for practical instruction in rearing trees, vegetables, and fruit, now form part of the educational appliances of nearly every public and private school in Austria. There are nearly 7,769 such gardens in Austria alone, not including Hungary. The gardens also comprise botanical museums and appliances for bee-keeping.

**THE AMERICAN ACADEMY OF MEDICINE** is endeavoring to make as complete a list as possible of the Alumni of Literary Colleges in the United States and Canada who have received the degree of M. D. All recipients of both degrees, literary and medical, are requested to forward their names at once to Dr. R. J. Dunglison, Secretary, 814 North Sixteenth Street, Philadelphia, Pa.

**LEPERS IN LISBON.**—With reference to the spread of leprosy in Portugal, the *Correio Medico de Lisboa* asks how much longer lepers will be allowed to use the omnibuses and other public vehicles in Lisbon. We imagine that even non-contagionists will admit that this is carrying the *laissez aller* policy a little too far.—*British Medical Journal*.

An epidemic of malignant diphtheria has broken out in Carbondale, Pa., and about seventy-five cases had been reported by October 3d. In many cases entire families are stricken down. Eight years ago an epidemic of the same disease visited Carbondale and did fearful damage.

**THE CELEBRATED PAINTING** of Rembrandt, called the "Anatomical Lesson," has been bought, it is said, by Mr. Ellesworth for the Institute of Art, of Chicago. It formerly belonged to the Princess de Sagan.

A COMPANY is putting down a shaft into Grand Avenue Cave, four miles from Mammoth Cave, for the purpose of bringing up the air and putting it into the rooms of a large hotel which they propose to build, both as a pleasure-resort and sanitarium.

**THE Berlin Academy of Sciences** has granted the sum of one thousand five hundred marks to Professor L. Brieger for the furtherance of his researches on ptomaines, and a like sum to Dr. Fleischmann, of Erlangen, in aid of his investigations on development.

**DR. CARL KOLLER**, who has achieved such world-wide renown in the discovery of the application of cocaine as a local anesthetic, has been appointed Instructor in Ophthalmology at the New York Polyclinic.

**PROFESSOR VIRCHOW** telegraphs from Berlin that the Organizing Committee of the Tenth International Medical Congress has been constituted by the election of himself President and Dr. Lasar Secretary General.

**ENGLISH** medical experts are now making strong arguments in favor of the corset. Thus, little by little, evidence accumulates to show that the corset has come to stay.—*Maryland Medical Journal*.

A good question for the antiquarian is whether the corset has come to stay, or the stay has come to corset.—**ED.**

In Austria there are only 218 homeopaths out of the whole number of medical men, which is 7,183; and only 44 of these profess to practice homeopathy exclusively, and the number also is said to be steadily decreasing.

**DR. LUTZE**, formerly assistant in Dr. Unna's clinic at Hamburg, has been invited to proceed to Honolulu by the Hawaiian Government, and to remain there some time, to study leprosy, and to investigate the new methods of treatment.

Little Johnnie Day lies here,

He neither cries nor frets;

He had just reached his thirteenth year—

Cigarettes.

[*Troy Press*.]

**LAST** year 1,356 persons died of delirium tremens in England.

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÂ."

VOL. VIII.  
[NEW SERIES.]

LOUISVILLE, KY., NOVEMBER 23, 1889.

No. 11.

*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the finest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.*

## Original Articles.

### REMARKS ON THE ALBUMINATE OF IRON.\*

BY JOHN A. OUCHTERLONY, M. D.

*Professor of Principles and Practice of Medicine and Clinical Medicine, University of Louisville.*

Although very many preparations of iron are official and many others are in frequent use which have not found a place in the pharmacopeia, yet it seems the number of these compounds is still increasing.

The fact is that iron is so important a remedy, is useful in so many diseases and so often demanded in a multitude of clinical states, that the ingenuity and skill of the chemist is ever stimulated to new efforts in the desire of producing a preparation that shall contain this substance in a form unirritating to the tissues with which it comes in contact, easily absorbed and readily assimilated; in other words, the most rapid and certain hematic.

It is believed that albuminate of iron, conforming to certain chemical and physiological requirements, will be found, in many instances, to be the most eligible iron compound at the disposal of the physician. Clinical experience extending now over a series of years has justified the high expectations formed of its desirability and power, while the facility with which it lends itself to varied combinations vastly enhances its value and scope.

In endeavoring to form an estimate of the

value of any preparation of iron it is to be remembered that the compound of iron in the blood is organic and of an oxydized character. According to Ringer's observations organic salts of iron are less astringent and stimulating than the inorganic salts of the same metal, and organic ferric salts possess greater chalybeate properties than do the ferrous combinations. The same author also remarks that protosalts are converted into persalts in the stomach and duodenum, very likely by the oxygen swallowed. Hence it appears that any form of iron given by the mouth, which is not already in the oxydized state, undergoes this change before it is absorbed from the stomach or intestine. Indeed it seems essential that it be in the ferric state in order that it may be appropriated.

According to Binz soluble preparations of iron combine with the albumen of chyme and form albuminates soluble in acid, and according to Ringer the soluble preparations of iron combine with albumen in the stomach. Insoluble preparations of iron, however, are but partially dissolved in this viscus, and that in very variable degrees. Ringer has also remarked that, according to most authorities, the iron in the blood combines with the albumen, and that very probably, like most other metals, it exists in the body only as an albuminate. The experiments of Quevenne long since demonstrated that the soluble preparations of iron are precipitated by the gastric juice, even when the latter is strongly acid, and Wundt thinks the precipitate is albuminate, mixed with oxide of the metal when the juice is alkaline.

Bartholow also believes that it is probably as albuminate that iron is absorbed

\*Read before the Louisville Clinical Society, October 27, 1889.

from the stomach and the intestinal canal. Bucheim goes somewhat further in his experiments, which led him to state that if a soluble preparation of iron be injected into the blood of animals, it soon appears as albuminate on such surfaces as pour out albuminous secretions. Mialhe held that after the entrance of an iron salt into the blood its power of acting as a ferruginous tonic depends upon its being decomposed by the constituents of the blood in such a way as to give rise to albuminate.

There is, then, on chemico-physiological ground good reason for believing that a compound of iron of organic oxidized character and already combined with albumen forms the preparation best suited for administration.

Heretofore the utility of the synthetic albuminate of iron had been restricted, because of the insolubility of the article supplied in the dry state, and which I used some years ago with rather unsatisfactory results. It was therefore a marked advance when it was successfully prepared in a soluble and permanent form, which was first accomplished by my friend Mr. J. A. Flexner, of this city.

Clinical observations attesting the value of iron albuminate are not wanting. Losio (*Revista Clin.*) has experimented with iron in order to find the quickest way to bring deteriorated blood back to its normal condition. For this purpose he used hypodermic injections of various preparations of iron; among these ammonio-citrate, lactate and albuminate were the best. The latter caused the least pain and did not give rise to abscesses. Dr. Blondell (*Progrès Medical*, 3, 89) records a case of chlorosis cured by albuminate of iron after failure of carbonate. Dumont claims that the albuminate of iron is more assimilable than other iron salts, less frequently occasions gastric disorder and produces a rapid increase of the iron compounds in the blood. According to the last observer it may be given in milk. Dr. TeGempt (an excellent translation of whose paper appears in Gaillard's Journal for September, 1889,) derived excel-

lent results from the solution of albuminate of iron in the treatment of ulcer of the stomach.

Although he considers it well adapted for subcutaneous injections, which was confirmed by Gerhardt, he did not make use of this mode for the reason that the preparation never gave rise to digestive disturbances when given by the mouth. In commenting on this preparation, he says it contains iron in the form of albuminated oxide which is absolutely free from acid, and consequently causes no coagulation or precipitation when mixed with milk, chyle, or other liquid containing albumen. It furthermore does not irritate the stomach, neither does it injure the teeth nor affect the mucous membrane of the mouth. Neither did the ingestion of this preparation produce gastric pain nor increase the same when present.

In my own practice I have found the various combinations of the albuminate of iron as made by Mr. Flexner, of this city, most useful in large numbers of cases, embracing almost all the varied conditions in which iron is indicated. Owing to its bland and unirritating quality and its rather pleasant taste it is easily administered to children, and constitutes, in my opinion, the best form for the administration of iron to them. It is exceedingly well borne in those numerous cases among women where irritability of the stomach is as prominent as the need of iron is manifest. In them its use may be continued even for long periods with evident benefit. I have administered it in cancer of the stomach with profound anemia, and observed marked toleration of it, and the patient temporarily improved under its use. In combination with quinia and strychnia it appears to be preferable to the syrup of phosphates of iron, quinia, and strychnia, being less unpleasant, more easily tolerated, and, in my opinion, more powerfully hematic.

The conditions best adapted for the administration of albuminate of iron, and in which I have observed the most striking effects, were those where anemia and de-

bility are associated with weak and irritable digestive organs. This condition is often encountered during convalescence from typhoid, pneumonic, and the severer forms of malarial fevers; and in hysteria, especially in middle-aged women at the change of life. In many cases of chronic uterine diseases, so often accompanied with anemia and an irritable state of the nervous system, the solution of the albuminate of iron, alone or in combination, has in many instances proved of signal service in my hands. It is hardly necessary and certainly not desirable to enumerate all the conditions under which this preparation of iron may be prescribed with advantage. It may, however, be stated in conclusion that wherever a pure, unirritating, and at the same time active hematic is required, the solution of the albuminate is in manifold cases the best of its class; certainly it has no superior.

### HYDROPHOBIA.\*

BY T. B. GREENLEY, M. D.

On the 17th of March, 1889, I was called in consultation to see Warren Arnold, eight years old, son of Turner Arnold, of Bullitt County. Up to this time I obtained the following history of the case from the attending physician: On the 1st day of February, just six weeks before, he was bitten on the right hand by a strange dog that passed the house. The wound was inflicted on the first and second fingers, the teeth entering just below the heads of the first phalanges of those fingers, and as the boy jerked his hand loose the teeth tore through the skin of the first finger down below the knuckle, and through that of the other to the end of it, tearing out the nail by the root. The wound in this finger was greatly lacerated and ragged, and bled quite profusely. His father took him to Louisville, I think, the same day, and had what is termed a "mad-stone" applied to the wounds, which was said to have adhered several times. About the second or third day after it was applied again, alto-

gether, at both visits, adhering and drawing some eighteen times.

The wound healed kindly, and the boy seemed to be doing well up to the forty-second day, when he complained of some uneasiness at the site of the wound, which seemed to extend up the arm and shoulder of that side. In a very short time he complained of stiffness of the muscles of the neck, which was directly followed by inability to swallow fluids. I saw him on the afternoon of the forty-third day after he was bitten, and just twenty-four hours after the first symptoms were manifested. His condition at that time was as follows: Temperature, 99.5°; pulse, 160, quite nervous, unable to swallow water, although thirsty and anxious to drink. When he would attempt to do so you could plainly see contraction of the muscles around the throat. Thinking, perhaps, he might be able to swallow something not the color of water, I got him to try some wine, which he thought he could swallow until he took the glass in his hand and looked at it. The muscles of deglutition began again contracting, when he turned his head aside, and handed it back, saying he could not swallow it. At this time he was not aware that his trouble was due to the dog bite, but thought he was taking typhoid fever. His father very properly, in order to quiet his mind, induced him to think this, as he had an attack of typhoid several years before.

As little could be done, or needed to be done, in his present condition, I advised an enema of sodium bromide to allay nervous excitement and procure sleep, and to watch the progress of the case. In the event of threatened or actual convulsions, hypodermic injections of morphia, enemata of hydrate of chloral, and inhalations of chloroform according to indications were to be given.

I did not see the boy again, but by request my friend, Dr. A. B. Applegate, who was with him most of the time afterward, furnished me the following well written notes of the case, from Monday morning, 18th of March, the next day after I saw him, my visit having been made in the afternoon:

\* Read at a meeting of the Hardin County Medical Society, June, 1889.

*The Notes:* "Monday, A. M., March 18th, difficulty of deglutition of fluids not so great as day before. Temperature, 102.2°; pulse, 140; very nervous and highly imaginative; appetite good; pupils dilated; no sleep; diarrhea. Treatment: Aconite, brom. potash, and hydrate chloral.

"Tuesday, 8 o'clock, A. M.: Temperature, 102.2°; pulse, 120; very nervous, and at times very wild; twitching of hands and arms; general pruritis; bowels and kidneys active; appetite ravenous; swallows with but little difficulty—if he drinks, slowly; has no fear of water, nor of noise or light.

"R. Brom. potash, 15 grs., and chloral hydrate, 5 grs., in syrup, every hour, commencing at 8 o'clock, A. M., and half an ounce of strong infusion of elecampane every three hours.

"2:30 o'clock, P. M.: Same temperature and pulse rate; terrible itching, and more nervous; same treatment.

"Wednesday, 20th: 6 o'clock, A. M., nervous condition improved; more quiet in every respect. Slept three or four hours; swallows food, liquids, and medicine with more ease. Same treatment. The above condition was unchanged till late in the evening, when he became almost unmanageable for an hour. His mind exhibited wild hallucinations, such as nursing an imaginary baby, petting squirrels, picking up beans, etc.; and if the least attempt was made to restrain him he became violent, but while quiet was rational and knew every person of his acquaintance. Had one or two attacks of fright, etc., during the night, but otherwise was very quiet.

"Thursday, 21st: 8 o'clock, A. M., temperature, 103.6°; pulse, 150, and weak; exceedingly nervous; refuses all food except oranges; had several violent spells, but of short duration; fought his friends, and in a moment would embrace them. About noon his most violent attack took place, and continued until 3 o'clock, P. M. His screams could be heard one quarter of a mile; he would plead for mercy from his imaginary enemies; complain of being blind; that he was going mad, etc. He had been sitting

up and walking about the room all day; could not induce him to lie down. About 3 o'clock he became so violent that by force we placed him in bed, and injected hypodermically  $\frac{1}{4}$  gr. morphia, which quieted him, and he slept well until 10 o'clock, P. M., when he was attacked by a severe (and the first) convulsion. In fifteen minutes another followed, and another, and another, till he had four, each increasing in severity. He then became quiet and called for food, but when offered him he refused it, and again became highly excited. By restraint we kept him in bed. At 12 o'clock we gave him another injection of morphia,  $\frac{1}{8}$  gr. Pulse, 180, and threadlike; rested well, but had spasmodic action of facial muscles and rolling of the eyes. At 2 o'clock, A. M., he gave two deep gasps and died. Exhaustion, notwithstanding the great amount of food taken continually up to the morning before his death, was progressive."

It is denied by some physicians that there is such a disease as hydrophobia, or rabies canina; they regard it either as tetanus or hysteria, in the latter case as the result of morbid imagination. But any observant medical man who has witnessed these diseases must admit a vast difference in their characteristics. To be sure, they are diseases strictly of a nervous character, but the phenomena presented are quite different in each disease. It must be admitted that hydrophobia has its analogue in tetanus in some particulars, to wit: both diseases are due to the infliction of wounds, and both have their periods of incubation, or latency, previous to the manifestation of the disease. In both we have spasmodic action of the muscular system, but varying in character. In tetanus we have both the tonic and clonic spasm; in rabies only the latter. In tetanus we commonly have trismus, but not in hydrophobia; neither do we have opisthotonus, which is always present in tetanus. In the latter we have no dread of or inability to swallow fluids in the absence of locked jaw; this is common in the former. The parallel of difference might be extended as to the curability of the two diseases. As to hyste-

ria, there is but little similarity in the manifestation of the two diseases. But whoever denies the existence of the disease, and alleges the symptoms to be due to mental excitement or to the imagination, has reflected or thought but little on the subject. Had this idea any foundation for truth, we would hardly witness the development of the disease in children or animals, as they think but little and imagine less.

Some authors say no case of hydrophobia has been cured, while Dr. Keen (Philadelphia Medical Times, March 18, 1871,) reports a case cured by the use of tincture of Calabar bean (physostigma) in doses of one or two hundred minims; and Dr. Watson collected a report of eighteen cases in which the same remedy was used, wherein ten cases recovered. (Practitioner, September, 1869.)

Of the cases bitten many escape the development of the disease. This is due mainly to the fact that a majority of persons are bitten through clothing, which wipes the poison from the animal's teeth. Of a collection of three hundred and twenty cases of persons bitten only forty per cent died of hydrophobia. It may occur to some that clothing might be a protection in the bite of a venomous reptile, but the virus is of a different character, and is secreted differently. At the roots of the front teeth of a rattlesnake is a sac which contains the poison, and when the animal bites deeply into any substance the sac is pressed upon, when the poison is forced down through a groove in the tooth into the wound. So it will be seen the clothing affords no protection to its entrance.

The question now arises, if we can not cure the disease, what can we do to ameliorate the terrible suffering while life lasts? More than a hundred remedies have been resorted to in the management of this affection, but virtually with but little result. When those cases above referred to were reported as being cured by Calabar bean, it raised great hope in the professional heart that a remedy of some efficacy had been discovered for the amelioration and cure of this terrible malady. But of late years it would

seem that the interest thus happily inspired has lapsed. Now the physician only has hope of, to some extent, relieving the severity of the symptoms, and making the path to death as smooth as possible; and probably this can be effected by the remedies employed by my friend, Dr. Applegate, as well as by any others. Perhaps in some cases chloroform by inhalation might be used in addition with advantage. All the known sedatives and nervines have been used, but with no better beneficial results than those above alluded to. Again, we might inquire, can there be any thing done in the way of prophylaxis against the development of this the worst of all afflictions? This question is now attempted to be answered in the affirmative by the celebrated Pasteur, of Paris. He contends that by inoculation with virus, modified by being passed several times through rabbits, he can prevent the development of the disease. The process of his plan is too prolix to be recounted here. But, although he and his friends claim great results from his mode of procedure, others say there have been more deaths from hydrophobia in France for the last two years than for the same length of time preceding, and even go so far as to say that some have died from the effects of the treatment with all the symptoms of hydrophobia. I believe the profession, to a very great extent, is losing confidence in the virtue of the theory.\*

Most all authors on the subject agree in advising excision of the wound, and, where a cup can be applied, to cup the part, and afterward scar it either with the actual cautery or nitric acid. I have treated one case in this way, a boy eighteen years old, who had been bitten on the morning of the day of operation on the leg. In twelve years there were no rabid manifestations. He, however, was bitten through clothing.

Dr. Bright, now of Lexington, Ky., pub-

\*Since writing the above I have written the report of the American Medical Association addressed by W. H. Brown, on Hydrophobia, delivered before the Fifth Annual Session of the Medical and Chirurgical Faculty of Maryland, of which he is chairman, on the 14th of August, 1871. The report of Pasteur and his friends makes a very plausible and gratifying showing of the efficacy of the method of prophylaxis against rabies by the attenuated virus inoculation plan.

lished a very rational plan of prophylactic treatment in the *American Practitioner and News* of September 15, 1888. He reports six cases, as follows: "In July, 1867, I saw a child just bitten on the hand, the wound bleeding slightly; cauterized and bound it up with cloth saturated with aqua ammonia, and gave her seven grains carbonate ammonia every two hours. Ammonia was given three weeks. No symptoms of rabies supervened. In the summer of 1875 I saw four men and a little boy who had been bitten by a mad dog. Applied raw cotton saturated with aqua ammonia, to be kept wet with the medicine. To two of them were given carbonate ammonia, ten grains every two hours, and to the others twenty grains acetate ammonia every two hours. Continued treatment three weeks. Thirteen years afterward no symptoms of hydrophobia had supervened, and they were in perfect health." He believes that if the blood of a person bitten is kept in an alkaline condition for several weeks, that it destroys or renders inert the virus of rabies, which is a very reasonable conclusion. It has long been known that the ammonium alkali is an antidote to the virus of venomous reptiles if injected into the circulation immediately after the infliction of the bite. In cases of children it would be more convenient to administer the chloride or acetate of ammonia, owing to the pungency of the carbonate. It also requires some care in keeping the latter without losing some of its virtues on account of its great volatility. I think, after the first day or two, it would not be necessary to exhibit the remedy at such short intervals as the doctor prescribes, but say every six hours for three or four weeks. This would, I think, sufficiently alkalinize the blood to neutralize or destroy the rabie poison.

In order to obtain more definite information respecting the character of the wounds and the treatment, I wrote to Dr. Bright, to which inquiries he very promptly responded. One of the men and the boy were bitten on the hand and arm, the other three men were bitten through clothing. He contin-

ued the application of ammonia by means of raw cotton until the wounds commenced suppurating. The alkalies were given first at intervals of two hours, and continued till the blood became alkaline, which was ascertained by examination of the urine; then at shorter intervals for three or four weeks.

There was no doubt of the rabid condition of the dogs, as cattle and hogs that were bitten went mad.

The earliest account of hydrophobia we have is by a Hindoo writer, Susruta, about one thousand years before Christ. He describes the symptoms of the disease very accurately, and advises prophylaxis about as is done to-day. Various Greek authors before the Christian era wrote on the subject, among whom are Aristotle, Democritus, etc.

In a collection of 220 cases by Thamhain, the period of incubation in 202 was from 3 days to 6 months. In 145 it extended from 4 to 13 weeks; one occurred after 4 years, and one after 5½ years.

As there is a general popular belief in the virtues of the mad-stone as a prophylactic against rabies, it might be well to say a few words in order to show the fallacy of such a view. It is held by a great many that this inert, inorganic body possesses the power to discriminate between the presence or absence of rabie virus in a wound, and as long as it will draw or stick poison remains; and on the contrary, when it fails to adhere, the poison is all abstracted. At first view, to the reasoning mind, this conclusion would seem to be absurd; but there is still, to some extent, a superstitious element remaining with many of our race; and in many things, if some mystery attaches, especially in the way of doctors or remedies, the more potent they are in our estimation.

When I commenced writing this paper I thought I would examine into the history of the so-called mad-stone, but on investigation I find it has no history. I made sure, if medical authors ignored the mention of it, we would have something on the subject by literary writers, but I can find nothing whatever said of it in any work I could

find. I examined some ten different medical authors on the subject of hydrophobia, also several encyclopedias, including the British, Chambers', Johnson's, and Appleton's, and also the "Medical Superstitions of the Middle Ages." I also inquired of scientific men in regard to it, but so far have been unable to learn any thing of its history. At last, not having seen one, I called on the owner of the one used in the case here reported. I found her to be quite an intelligent and polite lady. She very kindly showed me the stone. On examination externally it presents the appearance of a piece of wood that has been dressed and undergone petrification. But on inspection of the interior (the stone having been fractured longitudinally) it was more like some variety of soft stone, seeming to be fragile. The surface was quite dark and the interior brown. It was, altogether, about  $\frac{3}{4}$  x  $1\frac{1}{2}$  inches in measurement.

Geologically speaking it resembles, more than any rock I can think of, some of the varieties of the oölitic formation, which belongs to the Jurassic division of the secondary period, which was deposited just under the chalk formation of that period.

Before I saw one of these so-called mad-stones I had an idea that it was of a porous or cellular character, and that it was on that account it was made to adhere or draw, something on the order of a cupping-glass, by dipping it in hot water, which to some extent produced a vacuum in the cells. It being, however, smooth and solid, it is made to adhere by firm and regular pressure, which forces out the air between it and the part to which it is applied, on the same principle that the plate of an upper set of artificial teeth adheres to the roof of the mouth. Of course it would stick to the surface of sound skin as well as to a wound.

Mrs. C., the owner of the stone, had no knowledge of its history or composition, and only used it at the request of the afflicted. Its failure in this case seemed to cause her to doubt its efficacy as a prophylactic remedy.

I am apprehensive that the use of the

stone became popular among the people by its frequent use in cases which had been bitten through clothing wherein no evil results followed, and the stone received the credit as a preventive.

As to its use in case of mad dog bite, I would not object to its application if the patient had faith in its virtues, as I believe, rabies being truly a nervous disease, any thing we can do to satisfy or render the mind contented it is our duty to have done. But of course, at the same time, we should allow nothing in the way of reasonable prophylaxis to be neglected that promised good results.

WEST POINT, KY.

### TUBERCULAR PERITONITIS WITH TUBERCULOUS FALLOPIAN TUBES; REPORT OF A CASE.\*

BY EDWIN RICKETTS, M. D.

This disease has been seldom diagnosed previous to abdominal section. On the other hand, it has been mistaken for ovarian tumor and ascites.

That much berated procedure, abdominal incision, for obscure pelvic and abdominal ailments, has opened the door of the sacred visceral abiding place. It is an electrically lighted causeway along which we move to a certain diagnosis of many obscure ailments.

The literature of this subject outside of a few reported cases is almost *nil*, some authors barely mentioning it.

To the "tuberculosis of fallopian tubes" Dr. Skene in his latest book gives but twenty lines.

Greigg Smith estimates that near one hundred such cases have been treated by abdominal section in the past twenty years. Two died directly from the operation, three in from five to twelve months, and twenty five cases were of from nine months' to twenty-five years' duration. While he thinks the reports have been too favorable as to recovery, yet he says "there can be no doubt that a considerable number of cases of undoubted

\*Read before the Mississippi Valley Medical Association, Evansville, Ind., September, 1882.

tubercular peritonitis have been cured by abdominal section."

Ely Van de Warker diagnosed ovarian cyst, but the abdominal incision revealed beyond doubt tubercular peritonitis. For three months following the operation his patient was in a condition of invalidism, and then became a strong, robust woman.

Many cases are reported as cured, but this statement must be taken with much allowance. Nevertheless enough operative evidence has been given us to enable us to assert positively that lives have been prolonged and suffering greatly relieved thereby. This is sufficient warrant for the employment of bolder and prompter surgical measures in abdominal disease.

The surgeons say that the pathologists have failed to give a satisfactory explanation of the disease. In return the pathologists may say that in the majority of the cases reported by the abdominal surgeons a diagnosis was not stumbled upon until the sense of sight was brought to bear upon the abdominal viscera. This was so in the case I am about to report. Had I delayed section until a correct diagnosis had been made, such diagnosis would have been made only on the *post-mortem* table. This I deem sufficient reason for urging early the exploratory incision as a diagnostic measure.

Mrs. G., aged thirty-four, married ten years ago, was seen by me May 15, 1889. She had been confined to her bed for nearly four months, and was much emaciated. She had no specific history. Her father died at the age of thirty-three from heart disease. The mother was living, aged sixty-six, and in good health. Two sisters, aged forty and thirty-seven, were also living and healthy. Her oldest child, seven years old, is the only one living. The third gestation took place five years ago. It was at full term. This labor was tedious, and followed with puerperal fever of six weeks' duration, the patient not being able, as she expressed it, "to button her clothing around her for six months." For four years past coition has been excruciatingly painful. The patient had pneumonia two years ago, being con-

fined to her bed and room for nearly three months. There was no cough nor spitting of blood before or since the attack of pneumonia. The percussion note over the right lung was somewhat high in pitch.

The present illness began last December with abdominal pains and diarrhea. About January 15, 1889, she noticed that her bowels began to be distended, and that her respiration was considerably interfered with. This was relieved by tapping, April 24, 1889, by the family physician, who removed six quarts of fluid. Her pulse was 140, temperature 103°, skin dry. She was vomiting, little food having been retained for four or five weeks. Abdomen distended and very sore to the touch. No edema of extremities nor laryngeal inflammation.

On making a digital examination I found the uterus low down in the vagina and fixed. On bringing the finger against the cervix much pain was elicited. Owing to the extreme tenderness of the bowels, along with effusion of liquid from the abdominal cavity, I could not bring the desired counter pressure to bear above the brim of the pelvis with my left hand. Notwithstanding this, distinct sausage-shaped tubes could be easily mapped out, the weight of the abdominal fluid giving considerable counter-pressure.

Finding this state of things, I must confess that I ceased to consider the testimony given by the patient and husband as to non-specific trouble of any importance in the history of the case. Removal of the uterine appendages was advocated along with the fluid, and washing the cavity and its contents thoroughly with warm, filtered water.

She came into my "home" June 2d, and after a thorough bath the day before, along with a saline purgative the night following, the abdomen was opened June 4th at 10 A. M. The fluid (two quarts) was drawn off by means of Tait's large trocar. The omentum was adherent to the abdominal wall, and a mass the size of a fist was found studded with numerous tubercles. In getting through the omentum a piece the size of a man's thumb had to be tied off the surface, and mopped with perchloride of iron to control

the bleeding. The intestines were matted together and thickly studded with tubercles.

The right fallopian tube was dug out and ligated close to the fundus, care being necessary not to sever the tube on account of fragility. Bleeding was profuse; and as moist, hot sponge pressure failed to control it, perchloride of iron was freely applied. This tube was fully distended with caseous debris. The left fallopian tube was not so fully distended, but the adhesions were so firm that I did not deem it advisable to subject my patient to any more shock; so I washed out thoroughly, carrying the perforated end of a Keith's drainage-tube into the *cul-de-sac*, stitching the abdominal incision together and around the upper end of the tube.

Drainage was kept up through the tube for thirty six hours, at which time the tube was removed. Adhesive straps were applied, but from some neglect a fistulous tract made its way into the drainage tube tract. The patient's temperature dropped from 103° to 101°, touching 99° several times during the four weeks she was in the "home." The pulse dropped from 140 to 106, touching 90. Within a week the vomiting disappeared, her appetite returned, and her demand for food, retaining all that was given, was a happy surprise.

She began to gain in strength and flesh, going out of the "home" July 9, 1889, to her home. For an indiscretion in diet I was called to see her July 23, 1889, and found her suffering from an acute attack of diarrhea, accompanied with severe pain and exhaustion. She rallied somewhat for a few days, but died August 1, 1889. No *post-mortem* could be obtained.

The case presents for consideration:

1. My failure to diagnose the trouble previous to abdominal incision.
2. The lowering of temperature and pulse following the removal of the tubercular dropsical fluid, with laying of the viscera and peritoneum with warm water.
3. Non recurrence of the dropsical fluid.
4. The fragile condition of the tubal tissue and the proneness to free bleeding upon the slightest abrasion.

5. The good results obtained by applying perchloride of iron for oozing.

6. In this case was the operation justifiable, death resulting in eight weeks?

CINCINNATI, O.

## DIABETES MELLITUS.

BY C. J. RADMAKER, M. D.

The only positive evidence of the existence of this disease is the continuous presence of glucose in the urine of persons eating a mixed diet that is partly composed of carbohydrates. If the carbohydrates are withdrawn from the diet, the sugar in the urine will also disappear, but this will only take place after an abstinence of fourteen days or three weeks. The conversion of carbohydrates into sugar takes place during the process of digestion in both sick and healthy persons. In healthy persons this sugar is oxidized in the blood into  $\text{CO}_2$  and  $\text{H}_2\text{O}$ ; but this does not take place in persons suffering with diabetes, at any rate not completely, and consequently a large amount of sugar is found in the urine. In some cases where only a small quantity of carbohydrates is taken, the greater part of it is oxidized in the blood, and only a little appears in the urine. In other cases hardly any is oxidized, and the greater quantity appears in the urine.

The daily amount of sugar in the urine varies with or depends upon the amount of carbohydrates taken. The gravity of the disease depends upon the amount of sugar in the urine, which in some cases is only a few grams; in other cases as much as eight hundred to a thousand grams are passed daily. If a person is debarred from eating carbohydrates, the sugar will disappear from the urine, but he is not cured. A cure is only effected when the patient can eat carbohydrates as usual without any appearance of sugar in the urine. Why a person suffering with diabetes is not capable of oxidizing sugar into  $\text{CO}_2$  and  $\text{H}_2\text{O}$  is not known. There are several theories advanced, but none of them explain the matter satisfactorily. It is also

unknown what organ of the body is diseased, as an autopsy reveals nothing abnormal.

Some authors hold that the disease has its seat in the brain, while others attribute the malady to the liver. It is not even known whether the sugar in the urine is always due to the same disease. Clinical experience has shown that the majority of persons suffering with diabetes are corpulent, and that obesity has a tendency to produce the disease.

Diabetes is generally first recognized when a patient states that he is suffering with great thirst and that he passes as much as five or ten quarts of urine daily; he also complains of great bodily weakness and insomnia. On examination of the urine sugar is found in great abundance. From this we can conclude that the patient has been suffering with diabetes for some time.

The detection and estimation of the sugar is of such paramount importance both to the physician and patient that both should be able not only to detect it, but also to estimate the quantity. The reagents generally used for the detection of sugar in urine are Fehling's and Trommer's alkaline copper tests. When these solutions are boiled with solutions containing grape sugar, the oxide of copper is reduced to the yellow or red cuprous oxide. By these tests sugar is readily recognized. But for delicacy I prefer an alkaline solution of subnitrate of bismuth in Rochelle salt.

This test solution is prepared as follows: Four grams (3j) of Rochelle salt, 100 cc. (3iij) of distilled water containing 10 grams (150 grains) of caustic soda, or a solution of caustic soda having a specific gravity of 1.115, and 2 grams (30 grains) of subnitrate of bismuth.

These substances are mixed, and left in a beaker-glass until dissolved, heat being seldom necessary. The solution is then decanted, or, better, filtered, and put in a glass-stoppered bottle. This solution will keep for an entire year. When a little of this solution is boiled with urine containing sugar, the bismuthic oxide is reduced

to the black bismuthous oxide, which is precipitated. It is always advisable to boil the mixture for at least two minutes. This test will show the presence of a very minute quantity of sugar. Having satisfied yourself that the urine contains sugar, the next step is to estimate the quantity.

For this purpose Chambers and other eminent authorities recommend, fermentation of the sugar, by adding yeast to the urine, and noting the difference in specific gravity before and after fermentation at the same temperature.

But as sugar is not completely decomposed into alcohol and carbonic acid by the process of fermentation, it can not be used at all for the quantitative estimation of sugar in the urine. For an accurate quantitative estimation, Fehling's test solution of potassio-cupric tartrate or the alkaline solution of subnitrate of bismuth can often be resorted to.

Fehling's solution is prepared as follows:  
34.64 grams of  $\text{Ca SO}_4$ .

200 grams of tart. of soda and potash are dissolved in 1,000 cc. (1 liter) of caustic soda solution, having a specific gravity of 1.014. Every 100 cc. of this solution reduced when boiled with urine containing sugar represents 0.5 gram or  $7\frac{1}{2}$  grains of glucose.

*Treatment of Diabetes Mellitus.* The treatment of this disease is twofold. First, to keep the sugar out of the urine, and secondly to keep the patient well nourished. The only medicine I use in the treatment of diabetes is opium, and this is given for the purpose of producing sleep, and also to quench the excessive thirst; besides, it partially controls the excessive secretion of urine.

The balance of the treatment must depend upon the diet. The diet should contain but very little carbo-hydrates, if any; but some patients can not get along without starch. The diet then must be principally fat and albuminous. To this class belong meat of all descriptions: beef, mutton, veal, pork, fowl, fish, eggs, and cream. Of the vegetables the following may be taken

in any quantity: lettuce, spinach, asparagus, young beans, cauliflower, cabbage, cucumbers, and saccharin in place of sugar. Coffee, tea, and the astringent wines can also be taken. But every thing containing starch or sugar is to be avoided, namely, nuts, bread, potatoes, sweet wines, and beer. As bread is an article of diet that most patients can not do without, I have the following substitute prepared, which has answered all purposes in my practice. Rye or wheat-meal is mixed with water and kneaded; the water turns milky owing to the suspension of starch; this water is poured off, and fresh water added, and again kneaded. This is continued until all or nearly all of the starch is removed. The remaining dough, which is principally gluten, is then mixed with salt, butter, and yeast, and baked. This gluten bread makes an elegant substitute for ordinary bread. If this treatment is continued from four to eight weeks a cure can be promised in the majority of cases.

LOUISVILLE.

## Societies.

### LOUISVILLE CLINICAL SOCIETY.

Stated Meeting, October 22, 1889, Dr. William Cheatham, President, in the chair.

Dr. Ap Morgan Vance exhibited a fibromyoma of the uterus for the removal of which he had done a hysterectomy. The tumor so involved the uterus that the os and cavity could only with difficulty be made out on one side of the mass. It was nodulated quite solid and weighed fifteen pounds. The patient was thirty-six years old. She had menstruated regularly, but suffered great pain from tympanites and fecal obstruction. Indeed the latter symptoms made the operation necessary, as she was unable to pass feces except under drastic cathartics. The tumor was removed without difficulty, and but little blood was lost. The patient died of shock a few hours after the operation.

#### DISCUSSION.

Dr. W. O. Roberts made some remarks upon the latest method of treating shock, which is to place the patient upon a hot-water bed, thus

securing an equal distribution of heat through the body while the usual stimulants and restoratives are given.

Dr. H. A. Cottell said that some years ago he had written an article urging the surgeons to give atropia in abdominal operations as a prophylactic against shock. He based his theory upon the well-known physiological experiment, wherein, if the abdomen of a frog (the frog's abdominal and thoracic cavities are closed) be opened and the intestine or mesentery be pinched or otherwise irritated, or the frog's foot be crushed, the heart will be at once stopped in systole; in short, the animal suffers shock. If, however, the irritation be preceded by a dose of atropia, the intestine or any other part of the frog may be wounded to any degree without affecting the heart. This proves beyond question that atropia annuls the cardio-inhibitory reflexes which play the chief rôle in the phenomena of shock. He believes that a hypodermic injection of atropia preceding any serious surgical operation would forestall shock by preventing undue stimulation and overaction of the cardio-inhibitory centers.

The essay of the evening was read by Dr. John A. Ouchterlony; subject, Remarks on the Albuminate of Iron. (See page 321.)

#### DISCUSSION.

Dr. J. M. Mathews had used albuminate of iron in a number of cases, and found it admirable. In one case a lady who was delicate and anemic was much benefited by its use after having taken a thorough course of tonics, ferruginous and bitter, without effect. In another, a lady (also anemic) who supposed she had an idiosyncrasy for iron was able to take the albuminate for a long time without distress or distaste, and with decided benefit.

Dr. W. O. Roberts had used the albuminate, but not for a time of such length as to warrant the formulation of an opinion of its value as compared with other preparations. He was, however, pleased with its palatability and lack of irritative qualities.

Dr. Ap Morgan Vance had found a combination of albuminate of iron with mercuric bichloride,  $\frac{1}{10}$  of a grain to a fluid dram, to be a most eligible and useful remedy in some diseases.

Dr. Thomas P. Satterwhite was pleased with its action. The fact that it is a preparation of iron with which arsenic can be combined without precipitation, makes it of great value in the treatment of chronic malarial affections.

Dr. Douglas Morton asked if the feces were blackened by albuminate of iron as by other salts of this metal.

Answer (Dr. Ouchterlony): Iron passed black in the feces is iron that, having escaped absorption in the alimentary tract, has been converted into a sulphide. This is true of most preparations of iron when they have blackened the feces, although a small amount of previously assimilated iron may be excreted from the intestinal mucous membrane. If it be found that albuminate of iron does not blacken the feces, it will be a point in proof of its assimilability.

Dr. H. A. Cottell had used the albuminate of iron in several cases of anemia associated with gastric catarrh and flatulent dyspepsia with nausea. He was pleased with its palatability and non-irritating qualities. Theoretically there are many reasons based upon chemical and physiological grounds why the albuminate should be the most assimilable and efficacious of all the salts of iron. Whether therapeutically it can in all cases take the place of other preparations, the chloride for instance (as in the treatment of diphtheria) is a question which only long and large observation can determine.

The speaker, in a recent case of diphtheria (a girl ten years old), encountered such gastric irritability that the exhibition of the muriated tincture was impossible, a dose of from ten to fifteen drops acting at once as an emetic. Believing in the germicidal effect of the chloride of iron (or perhaps of free hydrochloric acid) in this disease, he improvised a prescription which met the requirement, and proved on exhibition to be very palatable and devoid of irritating effect. The recipe was as follows:

Ferri dialysati (ferric oxy-chloride)...f ʒss;  
Acidi hydrochlorici dil.....f ʒss;  
Syrupi aurantii cort., q. s. ad.....f ʒiij.  
M. Sig: Teaspoonful every three hours.

This makes with syrup of orange peel (made from the fresh peelings of the Florida orange, which contain very little tannic acid) a homogeneous preparation, palatable, non-irritating,

and therapeutically quite as efficacious as the muriated tincture of iron. My little patient took it with avidity.

Dr. Ouchterlony was of the opinion that the only good done by ferruginous preparations in diphtheria is to charge the blood with iron enough to compensate for the destruction of hemoglobin, which is great during the course of the disease. He had used the albuminate with happy effect in diphtheria.

Dr. William Cheatham finds the albuminate of iron to have a decided antiperiodic effect in some cases.

#### REPORTS OF CASES.

Dr. Douglas Morton gave his experience in the treatment of phthisis with carbolic acid, pulmonary gymnastics, etc. He had been treating the disease after this method for four years. He begins treatment with the administration of 3 gts. of the acid three times daily, increasing the dose up to 5 or 6 gts. The acid should be chemically pure.

With this medication is prescribed daily systematic exercise of the arms with and without dumb-bells, etc., the same to be taken in such a way as to call into play all the muscles essential and auxiliary to respiration, expanding the lungs in every part to their full capacity. In addition to this a respirator is used.

The speaker reported two cases in which this line of treatment had been carefully carried out.

CASE 1. An old lady had been the subject of phthisis for several years. She suffered from hectic, progressive emaciation, cough, night-sweats, and showed on physical examination a moderately large cavity in the apex of the left lung.

The lines of treatment usually in vogue, including Bourgeon's sulphureted hydrogen injections, had been faithfully tried. Under carbolic acid and gymnastics she improved, and the disease is now apparently at a standstill.

CASE 2. A colored man, middle aged, had pneumonia of one lung, from which he convalesced badly. Physical examination revealed a deposit at the apex of the other lung. The carbolic acid and accompanying treatment dissipated the symptoms in this case. The man is now apparently well. In all his cases the

doctor had found an early improvement in symptoms under this treatment. Forceful breathing is useful in expelling the excess of residual air which favors tubercular deposit.

#### DISCUSSION.

Dr. Ouchterlony had used this treatment with some good results. It is difficult, however, to estimate the effect of remedies in phthisis, because the disease, when chronic, has periods of remission uninfluenced by treatment. Fibroid phthisis runs a very slow course. The lungs are especially predisposed to tubercular deposit. When tubercular matter is elsewhere inoculated into animals, the lungs are among the first organs to give evidence of the disease. It is the hope of the therapeutists that carbolic acid and other germicides given by inhalation may reach and destroy the bacillus; but clinical experience so far gives it no fruition. Carbolic acid internally probably does little more than to prevent fermentative changes in the alimentary tract, and so improve the digestion and assimilation of food.

Pulmonary gymnastics were first advocated and practiced upon a definite scheme by Dr. Bothman. His article upon this subject, which appeared in the *New York Medical Record* some ten years ago, is classic to the subject.

The benefit to be had from daily systematic practice is unquestionable. The speaker preferred Indian clubs to the dumb-bells recommended by Dr. Morton, because in the use of the clubs the patient is called upon to make a far greater number of movements than are possible with the dumb-bells.

L. N. BLOOM, M.D.,  
*Secretary.*

#### BRITISH MEDICAL ASSOCIATION.

The eighty-seventh annual session was held at Leeds, August 13, 14, 15, and 16, 1889, the president, Mr. C. G. Wheelhouse, of Leeds, in the chair.

The president's address was delivered by Mr. Claudius G. Wheelhouse, F. R. C. S., Consulting Surgeon to the Leeds Infirmary. First was made a cursory review of the progress of medicine and medical education. He reviewed, in the light of abundant knowledge, the gradual transformation of

the position of medical and surgical knowledge in the time of our forefathers into that which they occupy to-day. This review, of course, did not fail to present abundant topics for congratulation; but Mr. Wheelhouse is as far as possible in his remarks from suggesting the motto, "Rest and be thankful." He claims, with all justice, that the practitioners of the present time have not been left behind in the race of life; that they have won their laurels and been faithful to their trust. But the president looks forward to even more important advances on the part of our profession in the future than those which it has obtained in the past. In order to have coming generations best fitted to carry forward the torch of scientific progress, and to give effective application to the secrets which the torch may lay bare, he urges with great earnestness a re-organization on an extensive scale of the present system of medical education, and of testing the possession of the qualifications for medical practice. He not only criticises severely the present system of examination for medical diplomas, but places with great care before his brethren and the country the outlines of an alternative scheme, both of training and of examinations, which, as he claims, the elements of hurry and worry, which have been so strenuously denounced Mr. Pridgin Teale in connection with existing examinations, would be as far as possible eliminated, a greater belief in the fairness and justice of examinations would be engendered and much more thorough securities would be taken than at present of the possession of knowledge, both theoretical and practical, required to make a safe and reliable practitioner.

A surgical operation in former times, said the president, was an ordeal of fearfully different magnitude from the present, and naturally enough the patient had a large say in the matter. Confidence in the operations themselves and in the skill of the operator were not then what they are to-day, and it must be remembered that when, as the only means of escape with life, an operation had to be performed, it had to be done

in all its unalleviated agony. Courage and endurance unfortunately are not given alike to all, and many a life which would be saved to-day was then voluntarily laid down, not simply for want of faith in the operator, but from sheer inability to face the terrible ordeal of bodily suffering involved.

A common reproach is often brought against medicine, that it is a skeptical profession; that its practitioners are essentially materialists in their views; that medicine as a science leads to free-thinking, and seeks in a rational explanation of every fact with which it is brought in contact to undermine our belief in things spiritual, and to lessen our faith in all we can not see and handle and account for; that constant contact with pain and suffering tends to numb our sympathies and to diminish our pity for the sufferings of mankind. On this point he ventured fearlessly to challenge any other calling or profession to produce a parallel to the modern development of public medicine, a science which seeks ever, even at the risk of its own extinction, to exterminate the causes of disease and death, and to eradicate from the world the very springs and sources from which they arise.

By the cultivation of bacteriology and cognate sciences he could picture to his mind the time when the whole range of zymotic and exanthematic diseases will be subdued and conquered. It will not be in our day that these triumphs will be won, but our successors will undoubtedly achieve them. Then will the victory of our science and the patient untiring efforts of the physician be acknowledged by the world.

A correspondence from several members of the Association, Sir Joseph Lister, W. H. Allicin, W. A. Meredith, and John Williams, with the Council criticising the conduct of the Journal, stated that, being very zealous of the honor of the Association, they must resign their memberships unless something was done. The Council in reply did not admit that the signatories of this letter were better judges than themselves or more solicitous for the honor of the Association or profession.

Mr. Lawson Tait moved and Dr. Robert Barnes seconded a motion which expressed satisfaction in the steps taken by Council for the management of the Journal. Carried. A motion that the traveling expenses of the representatives of the branches, at the meeting of the General Council in London, be paid by the Association, was carried.

A sermon was preached on the afternoon of the first day by the Bishop of Ripon (Dr. Boyd Carpenter) from the text, "I have compassion on the multitude." (Matt. xv, 32.) He said we were anxious to see a reconciliation between the claims of knowledge and of faith. It was only in the matters of lesser importance that there was a difference. The cardinal principles were the same. He compared medicine, law, and theology. Medicine had looked on religion as the nurse of hysteria and the mother of hallucinations, and religion had sometimes looked askance at medicine, imagining that this was a system which materialized and brutalized, and lead men to forget the higher vocations of their existence. Medicine and divinity should walk side by side. The triumphs of the one were the triumphs of the other; the heroisms of the former were the admiration of the latter. In the agony of Rork's Drift the physician and the chaplain fought together. If divinity had, among the islands of the sea, a heroism like that of Father Damien, consecrating his life to disease and death, medicine had had in its hospitals those brave men who had not hesitated to put their lips to the poison, and draw death to themselves to save the child or the weak.

This was the third time for the Association to hold its meeting in Leeds. The first meeting here was in 1843, when the membership was 1,600, now it is over 12,000. Branches have been established in Malta, Punjab, Griqualand, Bombay, Barbadoes, Tasmania, Cape of Good Hope, Stirling, Scotland, and Derry, Ireland. The death of Dr. Dennis O'Connor, who presided over the meeting in Cork in 1879, was reported. The past year has been a successful one financially. The establishment of a library

and reading room at the Association headquarters at London was making marvelous progress. The number of members on the books last year was 12,265. During the year 954 have been elected, 110 have died, and 212 have resigned, leaving on the books 12,897. The criticisms made on the management of the Journal were brought before the meeting and discussed. The publication of a certain script document was regretted. In respect to the advertisements it was stated that great care was taken, and the objectionable ones were few, and that no more would be expected to creep in. Then abolition of relative rank in the army was reported an object which had received much assiduous attention.

The inebriate's legislative committee, by Dr. Norman Kerr, of London, reported there had been a permanent measure for the benefit and treatment of diseased inebriates.

Mr. Rivington moved that it was the sense of this meeting that the members of the Royal College of Surgeons of England should have a voice in its management. There were about 12,000 members and about 1,000 Fellows. The management of the institution is in the hands of a council elected wholly by the Fellows. He contended that the constitution of the College was most illiberal, and that the members had a right to a voice in the administration of affairs. Carried unanimously.

The Section on Public Health was under the presidency of Dr. Edward Ballard, one of the medical inspectors of the local governing board. The president introduced the subject of Medical Officers of Health, their training and the conditions on which they should hold office. The requisites for a good and efficient medical officer of health are, first, he should possess himself of due learning. He must have a knowledge of disease, and hence be a medical man. No knowledge—I was going to say in heaven above—certainly in the earth beneath, comes amiss to him. To make an efficient health officer, a man requires to be trained. An acquisition of rare value, and all the

more desirable, is the possession of tact. A very lengthy discussion on medical officers of health followed, as this is a subject of peculiar interest in England just now, being up before Parliament. At the close of the discussion a resolution was offered and carried unanimously, that the health officer should not be dismissed from office without the consent of the local government board.

Dr. D. Hacke Take, LL. D., President of the Section on Psychology, read a paper on Provision for the Insane Poor in Yorkshire, and then made an address on Future Provision for Pauper Lunatics.

Dr. Joseph Coats, of Glasgow, President of the Section on Pathology and Physiology, made an address on The Nature of Constitutional Susceptibility to Disease, which was discussed by Professor Gardener, of Glasgow, ex-president of the Association.

Dr. F. W. Mott read a paper on The Pathology of Cardiac Failure. The paper dealt with the physiology of fifty cases of cardiac failure, and was based on the experience of the speaker as Lecturer on Physiology and Registrar at Charing Cross Hospital.

Dr. G. F. Crooke read a paper entitled The Histology of Bright's Disease.

Dr. F. H. Matteson, London, stated the results of his recent investigations in reference to deaf-mutism, and pointed out that in seventy out of eighty per cent of the two hundred cases which he had examined he found nasal growths. The removal of these growths in several instances had a beneficial effect, especially in mutes who were being educated on the oral system.

Prof. Guye, Amsterdam, read a paper on Aprosopia, or our inability to fix our attention, and other allied troubles in the cerebral functions caused by nasal disorders. He said that generally young persons who were so disordered were regarded as victims of overpressure in education, but he had found a number of them to improve by local treatment of the nose.

Mr. W. Hall read a paper dealing with some causes of backwardness and stupidity in children, and pointed out that by relieving

congestion of the lymphatic system a beneficial result was produced from the relief of congestion in the cranium.

The Section on Pharmacology and Therapeutics was presided over by Sir William Roberts. He contrasted very strikingly the activity of the present day in regard to the action of remedies and their application to disease and the apathy of forty years ago. He thought the time not far distant when therapeutics might claim a place among the exact sciences. He put the question, is there any harm in the use of antacids in the relief of acid dyspepsia if carried on for a long time? Do dyspeptics purchase present ease at the cost of some future detriment? With due precautions he thought the practice harmless. He discussed the relative antacid potency of the several articles sold in the shops, and then dwelt at some length on the relative treatment of uric acid gravel by the use of alkalizing agents.

Dr. J. Leech, Manchester, opened a discussion on hypnotics and analgesics, and Dr. J. Gordon, Aberdeen, described his experiments with urethane.

The president of the Section on Pediatrics, Mr. Thomas Scattergood, made a few remarks and introduced Mr. Asby, of Manchester, who formally opened the discussion.

In the Section on Laryngology Mr. H. T. Butlin, of St. Bartholomew's Hospital, presided. Tonsillitis, its varieties and association with rheumatism, and Perichondritis of the Larynx, its etiology, pathology, symptoms, and treatment were fully discussed. Dr. R. H. Scanes described his experience in throat and nose affections in children, as causes of functional nervous disorders. Dr. D. Newman reported a case of laryngeal carcinoma complicated with tuberculosis, remarking on the rare coincidence of these two diseases.

The Section on Otology, over which Dr. George P. Field presided, was opened by the president relating his experience with a large number of cases of aural exostoses. The rarest form of this disease consists in a general thickening of the walls of the osseous meatus. In practice, the examples of exos-

tosis usually met with were those affecting only a limited area of the meatus, their causation being some local source of irritation of the ear. There were as yet no conclusive data for the supposition, that syphilis, scrofula, gout, or rheumatism influenced their production, nor did heredity appear to have any special determining cause. He was first induced to enunciate the opinion that these growths were due to the irritation of the ear by salt water, introduced repeatedly by a long course of sea-baths, by the singularity of the fact that four of his patients, who used to bathe together for long periods, on the south coast of Ireland, had each to be operated on for double ivory exostoses. He had met with numerous subsequent exemplifications of the correctness of this view. It was an unique experience to find these exostoses among hospital patients, who as a rule rarely exposed their ears to water. It was almost invariably male patients who were the subjects of ivory exostosis. Some authors recommend a masterly inactivity till the growth has attained its full development. His experience was that it was far better to operate while there was still room to guide the drill, were that necessary. The danger and difficulty in operating when the ear was full was very great. He had found the employment of the dental engine a uniformly satisfactory measure. In multiple exostoses he found it imperative, to prevent a repetition of the trouble, to drill the apices of all.

Sir William Dalby described his method of treating aural exostosis. He found the use of the electric drill lessened the time required for the operation, and, as the revolutions were two thousand five hundred per minute, the use of force was unnecessary, and on account of the heat the hemorrhage was less. Another advantage was that there was no tendency on the part of the drill to project into the cavity after the growth had been penetrated. His opinion was that such growths should be limited to those cases where the passage had been entirely blocked. He always advised patients to be careful not to put their heads under water.

Mr. Marmaduke Shield, London, described a method of treating aural exostosis by displacing the auricle, which he said was especially advantageous in cases where the opening of the ear was small.

Dr. T. Barr, of Glasgow, read a paper on *The Non-operative Treatment of Aural Exostosis*.

Dr. R. Ellis, Newcastle, gave an instance of the removal of an osseous growth which simulated a foreign body and produced deafness. He produced the specimen, and said its removal had the effect of restoring the patient's hearing.

In the Section of Obstetrics the president, Dr. C. J. Cullingworth, Obstetric Physician to St. Thomas' Hospital, London, dwelt in his opening address on the great advantages which had followed from the introduction of the anti-septic method in obstetric practice. He dealt with details of treatment which might be beneficially observed, and spoke of the necessity of simple precautions with respect to newly-born children so as to avoid dangers. Reviewing the work about to be done by the session, he referred to the strong differences of opinion among the rival schools, and said that the want of forbearance rose from the fact that the light of scientific inquiry had but recently been brought to bear upon the study of gynecology. We are still in the dark as to the pathology of some of the most common diseases to which woman is subject.

Dr. Braxton Hicks, F. R. S., opened a discussion on the treatment of placenta previa.

The president of the Section on Ophthalmology was Mr. George Anderson Critchett, who in his opening address claimed for ophthalmology that it had not lagged reluctant in the race of scientific knowledge in the nineteenth century. Alluding briefly to the best method of dealing with immature cataracts, the importance of which subject was becoming more and more recognized by ophthalmic surgeons, he said they might broadly divide the recognized operative methods into two classes—that which dealt with the immature cataract by immediate extraction, and that which involved an artificial ripen-

ing of the lens before its extraction. He mentioned the different plans which had hitherto been suggested for dealing with immature cataracts, and expressed his opinion that it was probable that the best solution of the question would be found in a happy union of the two methods.

Dr. Pridgin Teale, Leeds, discussed further the subject of cataract.

The address of the president of the Section on Medicine was made by that officer, Dr. J. E. Eddison, of Leeds. The doctor declined the privilege of a lengthy address in medicine. He outlined the work of the section and anticipated much pleasure, especially from the efforts of some American workers. He regretted that medicine was so split up into sections, as he was sure there were some things to be discussed which would be the better for the presence and participation of their surgical brethren.

Dr. R. Douglass Powell, London, read a paper on *The Clinical Aspects of Chronic Tubercular Diseases*, which was fully discussed.

The president of the Section on Surgery, Mr. T. R. Jessop, Leeds, made his address, taking for his subject, *The Treatment of Cancer of the Rectum*. A very extended discussion followed, which occupied almost the whole session, for the general interest taken in the subject was very great. Those speakers who had a large experience with inguinal as against lumbar colotomy lauded it in the most favorable terms. Several spoke of it slightly, but they were gentlemen who had not had much experience in excision of the rectum. The unanimity of the discussion was its most remarkable feature in favor of inguinal as against lumbar colotomy. The president's experience in seven cases would lead him to continue the plan of excision till he found reason to change it.

Mr. E. Stanmore Bishop, of Manchester, showed a splint for cradle for excision of the hip joint and osteotomy. The utility of the cradle was very great.

Mr. Mayo Robson, Leeds, showed a patient who had suffered from a biliary fistula

for fifteen months, which he had cured by suturing the gall-bladder to the bowel, and thus returning the gall along its natural channel. This operation had not hitherto been done, and it has rendered an incurable trouble amenable to treatment.

## Reviews and Bibliography.

Physician's Visiting List and Reference Book. Price, 75 cents, net. J. H. Chambers & Co., Publishers and Dealers in Medical Books, St. Louis, Mo.

Eating for Strength, or Food and Diet in their Relation to Health and Work, together with several hundred Recipes for Wholesome Food and Drinks. By M. L. Holbrook, M.D., Professor of Hygiene in the New York Medical College and Hospital for Women; Editor of *The Herald of Health*; Author of "Hygiene of the Brain," "How to Strengthen the Memory," etc. New York: M. L. Holbrook & Co.

Electricity in the Diseases of Women, with Special Reference to the Application of Strong Currents. By G. Betton Massey, M.D., Physician to the Nervous Department of Howard Hospital, late Electro-Therapeutist to the Philadelphia Orthopedic Hospital and Infirmary for Nervous Diseases; Member of the American Neurological Association, etc. Philadelphia and London: F. A. Davis, Publisher. 1889.

A Text-Book of Animal Physiology, with introductory chapters on General Biology, and a full Treatment of Reproduction: for students of Human and Comparative (Veterinary) Medicine and of General Biology. By Wesley Mills, M. A., M. D., L. R. C. P. (Eng.), Professor of Physiology in the McGill University and Veterinary College, Montreal. With over five hundred illustrations. New York: D. Appleton & Co. London: Caxton House, Paternoster Square. 1889. Price, \$5.00.

An Introduction to Pathology and Morbid Anatomy. By T. Henry Green, M.D., Physician to Charing Cross Hospital and to the Hospital for Consumptives and Diseases of the Chest, Brompton; Examiner in Medicine to the Conjoint Examining Board for England; Late Lecturer on Pathology and Morbid Anatomy at Charing Cross Hospital Medical School. Sixth American from the seventh English edition. Revised and enlarged by Stanley Boyd, M. B., B. S. (London), F. R. C. S. (Eng.), Senior Assistant Surgeon to Charing Cross Hospital,

and Surgeon to the Paddington Green Hospital for Children; Lecturer on Anatomy in the Charing Cross Hospital Medical School, and formerly Pathologist to the Hospital. Illustrated by one hundred and sixty-seven fine engravings. Philadelphia: Lea Brothers & Co. 1889.

Chemistry, General, Medical, and Pharmaceutical: including the Chemistry of the United States Pharmacopeia. A Manual of the General Principles of Science, and their applications in Medicine and Pharmacy. By John Attfield, F. R. S., M. A., and Ph. D. of the University of Tübingen, F. I. C., F. C. S.; Professor of Practical Chemistry to the Pharmaceutical Society of Great Britain; one of three Editors of the British Pharmacopeia, 1885; Reporter on the British Pharmacopeia to the Medical Council; Author of a Handbook on Water and Water Supplies, etc. Twelfth edition. Philadelphia: Lea Brothers & Co. 1889.

"The remarkable Catalogue of Medical Books and Journals issued by Dr. A. E. Foote, of 1225 Belmont Avenue, Philadelphia, has the same relation to the ordinary commercial catalogue as the Index Catalogue of the Library of the Surgeon General's office has to the ordinary catalogues. It is now being issued, being complete as to hygiene, yellow and other fevers, obstetrics, surgery, anatomy, practice, etc. When fully completed it will include over 14,000 titles. This remarkable catalogue is sent free to every physician requesting it on headed paper, or by including his professional card. It is indispensable to any practitioner who thinks or writes. This is undoubtedly the largest stock in the world. He issues similarly complete catalogues on chemistry, physics, and geology, and on all other branches of science. A natural taste for mineralogy has led Prof. Foote to accumulate the largest stock of minerals in the world, over 100 tons; these he sells at the ridiculously low price of \$5 and \$10 per 100 good specimens, carefully labeled, and 100 labeled crystals for \$1. Price list sent free."

Dr. I. N. Love, of St. Louis, announces that in January, 1890, he will issue the first number of the *Medical Mirror*, which will present (monthly) original papers and an epitome of current literature, domestic and foreign. It is stated that the *Mirror* will not hesitate to be personal if necessary, but nothing unkind or unjust shall knowingly ever enter its columns. The subscription price will be \$2.00 per year, in advance.

## Correspondence.

## LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Mr. Stanley Boyd is carrying out some experiments at Charing Cross Hospital with regard to the usefulness of frog-skin grafts. According to Mr. Boyd, frog-skin grafting was first proposed by Dr. Allen in 1884, and subsequently practiced successfully by Dr. O. V. Petersen and others. Still more recently, a surgeon at St. Petersburg has brought forward four cases of long-standing intractable, extensive and deep ulcers of the leg, foot, and thigh, in which, after all ordinary means had failed to produce a cure, the grafting or transplantation of grafts of frog-skin was invariably followed by a permanent healing in from nine to fourteen days. An ordinary frog is taken, and the lower portion of its body is immersed in a solution of corrosive sublimate (one to one thousand) for five minutes; then the author pinches up, by means of a forceps, a piece of skin in the abdomen, and cuts out as many grafts as are required, each of the size of a finger nail. Having washed the pieces as well as the ulcer with a four-percent solution of boracic acid, he carefully places the grafts on the granulating surface and covers the part with a layer of boracic gauze and a piece of tow, fixing the whole with waxed cloth and a starched gauze roller bandage. The dressing is changed and the ulcer first washed on the third or fourth day. In all cases of extensive and badly cicatrizing ulcers this skin-grafting is said to be indicated. The results of Mr. Stanley Boyd's experiments are being watched with great interest.

The Board of Commissioners in Lunacy for Scotland in their last report very strongly support the policy of removing pauper patients from asylums and placing them with private families. A good deal of nice judgment is needed in deciding whether a patient is fit for the change, but in the opinion of the commissioners it ought certainly to be tried as early as possible. The patients are placed in families so circum-

stanced that the patient must take a place in the domestic circle, and it is no doubt this constant presence and example of sane persons in the same class of life which reacts upon the whole behavior of the patients and ultimately upon their minds. It is found that persons who have been so boarded out are more contented, and they are in a better state of health both bodily and mentally. Another advantage of the system is that it is found to be less costly to the rate payers. Under the training they get from their guardians many of the patients learn to maintain themselves by their own earnings. Others are found so useful that they are claimed by their relatives, and even where neither of these results are reached a very large number learn to defray a portion of the expenditure involved in their support. The medical officer to whom the commissioners refer in this part of their report very pertinently remarks that a system which secures such advantages to harmless insane well merits some extension.

The following extraordinary story has just been freely commented upon in London. It appears that quite a sensation has been created at one of the Paris hospitals by the arrival of a party of peasants conducting a little boy twelve years of age, enveloped in a thick blanket, with his arms secured with chains fastened by a couple of strong padlocks, and his face covered with a sort of mask carefully secured. The unfortunate child was bitten by a dog some fourteen days before his arrival in Paris, and all went well until the day previous to his appearance under the escort, when, while at play, he told his companions to run away or he would bite them. This was enough for the villagers, who, panic-stricken with the bare thought that the boy might be affected with rabies, approached stealthily, threw a blanket over him, and then bound him securely in the manner described. The unlucky child not only presented a most grotesque appearance, but was quite famished into the bargain. He is retained at the hospital, but the idea prevails that the whole thing has been a false alarm.

Dr. Oliver, in a paper upon Industries and their Pathological Consequences, drew attention to the fact that lead-working still remains one of the most unhealthy occupations which there are. The lead miner does not suffer in health any more than any other worker under ground, as the ore is not in a condition to be absorbed by the body; but lead smelters and all engaged in the manufacture of lead, particularly white lead, run a very great risk of being contaminated sooner or later. At the present time Tyne-side is the chief center of the lead trade, and it unfortunately affords a magnificent opportunity of studying the phenomena of plumbism in all the phases of its development. According to Dr. Oliver there is at least one type which is rarely seen elsewhere, and which attacks those who have been only engaged in the work for a few months or even weeks. It is a very fatal disease, and chiefly attacks young girls from seventeen or eighteen up to twenty-three years of age. They rapidly display symptoms of this form of toxemia in the form of severe headache, followed by colic, blindness, and, unless they speedily leave work for a considerable period of time and undergo most careful treatment, the fatal result is rapidly ushered in, usually with epileptiform convulsions and coma. It is remarkable that but little trace of lead is found in their bodies after death, perhaps not more than a few grains in the internal organs after they have been subjected to the most complete and exhaustive examination. When death is thus rapidly produced by the effects of lead, no microscopical or naked-eye changes are observable in the organs after death. In the more chronic affections which are produced by lead the symptoms do not appear in the form of colic, with which one is so well acquainted in painters and other workers in lead, but rather affect the kidneys and the nervous system, producing a form of Bright's disease and numerous obscure paralyses, which, excepting that they occur almost exclusively in lead workers and yield to suitable eliminants, display nothing whatever characteris-

tic in their course to distinguish them from any other form of paralysis.

Hitherto in the metropolis it has not been regarded as the duty of any one to acquaint the authorities with an outbreak of an infectious disease. The Local Government Board has issued a circular reminding every head of a family that after the 30th of October it will become his duty to inform the medical officer of his district of the outbreak of any of the scheduled diseases in his house, all of them being of an infectious nature. Although the responsibility rests upon the head of the family, to make doubly sure, any person who may be in charge of a patient suffering from infectious disease is required to communicate the fact unless he or she can be assured that it has been already notified. The penalty for neglect is a fine of two pounds, and a like penalty is imposed upon doctors who may fail to make a report prescribed by law.

The founder of the Hospital for Women, Soho Square, Dr. Prothero Smyth, has just died, aged eighty.

The question of short-hand for students of medicine has gone so far that an examination in short-hand is announced to be held shortly in the Examination Hall, Thames Embankment.

Dr. Vaughan recommends that in infantile diarrhea the administration of milk should be entirely stopped, as it simply affords nutriment to the bacteria. In place of it beef-tea, rice-water, or pure water should be given, and this should be kept up for some days until the milk bacteria have probably died out.

LONDON, October, 1889.

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## Abstracts and Selections.

THE DREAD OF DEATH.—Sir Lyon Playfair, in a letter to Junius Henri Browne, author of a paper with the above title, says: "Having represented a large constituency (the University of Edinburgh) for seventeen years as a member of Parliament, I naturally came in contact with the most eminent medical men in England. I have put the question to most of them: 'Did you,

in your extensive practice, ever know a patient who was afraid to die?' With two exceptions they answered, 'No.' One of these exceptions was Sir Benjamin Brodie, who said he had seen one case. The other was Sir Robert Christian, who had seen one case, that of a girl of bad character who had a sudden accident. I have known three friends who were partially devoured by wild beasts under apparently hopeless circumstances of escape. The first was Livingstone, the great African traveler, who was knocked on his back by a lion, which began to munch his arm. He assured me that he felt no fear or pain, and that his only feeling was one of intense curiosity as to which part of the body the lion would take next. The next was Rustem Pacha now Turkish ambassador in London. A bear attacked him and tore off part of his hand and part of his arm and shoulder. He also assured me that he had neither pain nor fear, but that he felt excessively angry because the bear grunted with so much satisfaction in munching him. The third case is that of Sir Edward Bradford, an Indian officer now occupying a high position in the Indian office. He was seized in a solitary place by a tiger, which held him firmly behind the shoulders with one paw, and then deliberately devoured the whole of his arm, beginning at the end and ending at the shoulder. He was positive that he had no sensation of fear, and thinks that he felt a little pain when the fangs went through his hand, but is certain that he felt none during the munching of his arm."—*Science*.

**THE TREATMENT OF ENDOMETRITIS**—Dr. Bock, assistant physician to the Hôpital St. Pierre, in Brussels, gives, in *La Clinique*, some notes of a series of cases of endometritis in which very satisfactory results were obtained by the use of Canquoin's paste applied to the interior of the uterus. Dr. Bock does not give the strength of the preparation, and this is not always the same in various continental formularies. The paste is made by mixing one part of chloride of zinc with two parts, or according to some formularies with one part, of flour, and enough water to enable the mass to be kneaded into the required form. For the uterus, of course, the form required was that of a stick of such a length as to reach from the fundus to the external os. A careful measurement had, necessarily, to be previously taken with the sound, and the cavity was soaked out with a sublimate solution. The stick of Canquoin's paste was then introduced and retained by

means of a plug of cotton wool. For three or four hours the patients sometimes suffered a certain amount of pain, but this was by no means unbearable, and frequently there was no pain at all. Vomiting was occasionally produced in very sensitive subjects, but in none of the fourteen cases in which this treatment was adopted was there any pyrexia or other complication. The patients were kept in bed for a few days, and warm antiseptic injections given. The cantharide produced a slough to the depth of from two to five millimeters, which came away, sometimes revealing a portion of the interior, and even showing the commencement of the fallopian tubes. Dr. Bock considers that this treatment is suitable, where the cervical canal is sufficiently patent in all cases of chronic simple endometritis, as well as in fungoid or hemorrhagic cases, and that it is peculiarly beneficial in cases of gonorrheal origin, and he does not find that chronic or subacute inflammation of the uterine appendages forms any contra-indication. His results agree with those of MM. Poulton and Dumontpallier, who first recommended this treatment, and who were successful in thirty-eight out of forty cases in which they employed it.—*London Lancet*.

**TREATMENT OF PURPURA HEMORRHAGICA WITH NITRATE OF SILVER**—Dr. Poulet has a communication on the treatment of purpura hemorrhagica with nitrate of silver, in the *Bull. gen. de Therap.*, May 30, 1889. The author relates two characters, ie and severe cases of purpura hemorrhagica, which promptly recovered when nitrate of silver was given internally. The first was that of a boy twelve years of age, with a family history of tuberclosis and albuminuria, who, eight days previously, had been attacked by a petechial eruption, culminating in profuse epistaxis, which rapidly reduced him to a bloodless condition. Poulet ordered tincture of the chloride of iron and the acid infusion of roses, and, as they did not check the hemorrhagic tendency, he followed it up on the following day by plugging the nostrils and giving subcutaneous injections of ergotine. The bleeding, however, continued as before, and the condition of the patient became critical. He then resorted to nitrate of silver, in doses of one fifth of a grain, twice a day, incorporated with bread crumb and given after food. The next day a manifest improvement had taken place, and in the course of three or four days the drug could be discontinued. The lad gradually recovered, but the loss of blood

had been so abundant that it was years before he ceased to be delicate and anemic. The second case was that of a young woman twenty years old. Eight days after her last menstrual period purpuric spots made their appearance, with frequent attacks of bleeding from the nose, stomach, and bowels. She was fairly well nourished, and lived in the open country. Her previous health had been good, but for some weeks past she had experienced a feeling of lassitude, with loss of appetite. The eruption was most marked at first on the lower extremities, but soon became general. Various anti-hemorrhagic remedies were tried, but without any marked effect on the bleeding. There was slight albuminuria; legs a little puffy. Under these circumstances he ordered one eighth of a grain of nitrate of silver in a pill, three times a day. The effect was so marked that within four days sight and hearing were restored, and the purpuric patches began to fade. The hemorrhages ceased after the first day of the exhibition of the nitrate. Twelve pills in all were taken, and they sufficed to effect a cure.—*London Medical Recorder*.

**NERVE EXHAUSTION AND OPIUM.**—The revelations following the death of Mr. Wilkie Collins may perhaps tend to increase the pernicious opium habit among those who are, or who believe themselves to be, in need of some extra comfort or support. The accounts given by Mr. Edmund Yates and by Mr. Hall Caine differ in some respects, although they agree as to the relatively large amount of laudanum habitually taken by the deceased *littérateur*. The former speaks of Collins as a martyr to nerves and gout, and seems to infer that the drug was resorted to for the relief of pain. The latter, in an elaborate report of a conversation held early in 1888, professes to give the novelist's apologetic explanation for his practice. He took laudanum "to stimulate the brain and steady the nerves," and he had been in the habit of taking a wineglassful of laudanum many times a day for fully twenty years. Few things are more lamentable than the obvious cost at which much literary work has been accomplished. DeQuincey, Coleridge, Bulwer Lytton, and Wilkie Collins stand out as warnings against the folly of over-taxation of mental powers, and as examples of the habitual indulgence in opium. Rosetti, with chloral hydrate, and more recently the actor Damala, with morphine and cocaine, show the same form of weakness in resorting to other remedial (!) measures. It would be invidious to attempt to enumerate

well-known names in literary and artistic circles of men whose work has been carried on beyond reasonable limits under the influence of alcohol. The lesson to be learnt is that brain power has its limitations, as much as muscular power. Overwork produces exhaustion in both cases. Physiological laws can not be set at defiance. So far as opium is concerned, it undoubtedly diminishes the susceptibility to external stimuli, and hence may enable a man whose attention is diverted by pain to obtain relief, and perhaps to concentrate his thoughts more fully upon some particular point; but, as a mental "stimulant," its employment is to be deprecated as unsound and dangerous. The constant need engendered by its use does not strengthen the position of a "stimulant," so often erroneously claimed for this drug—*London Lancet*.

**THE REGULATION OF SLEEP.**—Insomnia is rightly regarded as one of the marks of an overwrought or worried nervous system, and conversely we may take it that sound sleep lasting for a reasonable period, say from six to nine hours in the case of adults, is a fair test of nervous competence. Various accidental causes may temporarily interfere with sleep in the healthy; but still the rule holds good, and a normal brain reveals its condition by obedience to this daily rhythmic variation. Custom can do much to contract one's natural term of sleep, a fact of which we are constantly reminded in these days of high pressure; but the process is too artificial to be freely employed. Laborious days with scanty intervals of rest go far to secure all the needful conditions of insomnia. In allotting hours of sleep it is impossible to adopt any maxim or uniform custom. The due allowance varies with the individual. Age, constitution, sex, fatigue, exercise, each has its share of influence. Young persons and hard workers naturally need and should have more sleep than those who neither grow nor labor. Women have by common consent been assigned a longer period of rest than men, and this arrangement, in the event of their doing hard work, is in strict accord with their generally lighter physical construction and recurrent infirmities. Absolute rule there is none, and it is of little moment to fix an exact average allowance provided the recurrence of sleep be regular and its amount sufficient for the needs of a given person, so that fatigue does not result in such nerve prostration and irritability as render healthy rest altogether impossible.—*Ibid.*

**DILATATION OF HEART.**—Case: A man, forty years old, a miller by occupation for the past thirteen years, he has always worked at night. He does not drink, but is a heavy smoker. Has always enjoyed good health, and has gained fifty six pounds in weight in the last few years. Three months ago he had a sudden attack of "goneness" over the region of heart. He grew pale and almost fell, and thought he was going to die; but he did not lose consciousness. He had no vomiting or headache, no disturbance of vision. He had vertigo for some minutes, and felt weak for the rest of the day. He had another attack two weeks ago and another to-day. He has not been at work for some time, by advice; but he feels able to go, and says he seems well. He has no palpitation or dyspnea.

Examination reveals a blowing murmur at the apex of the heart, and shows the heart sounds to be very indistinct and the heart's action to be very weak.

The patient is suffering from dilated heart, with probably one of two conditions, either a fatty degeneration or a fibrous myocarditis, which can not be learned during his life.

The prognosis is decidedly bad. Of this I am very sure. He may drop dead at any moment. In most cases it is best not to acquaint the patient with this fact; for if we do, the dread hangs over him and perhaps may shorten his life. But relatives should be informed fully, and the patient should be made to stop his business and give up bad habits. In this case smoking must be stopped—gradually, not suddenly; and a course of digitals, iron, and compound tincture of cinchona promises the most.—*Belle-vue Hospital Clinic Reports, Med. and Surg. Reporter.*

**REPORTED DEATH UNDER NITROUS OXIDE.** It has been demonstrated by Dr. Dudley Buxton in some careful experimental work that nitrous oxide *per se* does not possess any depressant action upon the heart, but rather tends to strengthen and slow cardiac force and rhythm. When the dentist, however, both operates and administers the gas, there is always a danger lest the anæsthesia should not be profound enough, and so the patient, feeling the pain while in the post-narcotic stage, incurs the risk of reflex inhibition of the heart, so liable to appear at that time. Intent upon his own work the extractor can not watch his patient as he should be watched, and thus grave perils are incurred. It is most deplorable that so

safe an anæsthetic as nitrous oxide has been proved to be should be blamed for fatalities which while occurring under nitrous oxide, are not directly due to that agent. All skilled anæsthetists seem to agree that there is more danger to be apprehended from an insufficient supply of nitrous oxide than from pushing that agent to profound narcosis. Owing to the very transitory period of unconsciousness obtained by nitrous oxide every second of time is valuable, and hence the peril in allowing one individual to undertake a double function—to administer gas and extract teeth—arises not only from the impossibility of operating and watching the patient simultaneously, but also from the loss of time incurred in exchanging the face piece, etc., for the extracting forceps.—*London Lancet.*

**COW DISEASE AND SCARLATINA.**—Without presuming to throw any new light on the supposed connection between disease in the cow and scarlet fever in the human subject, I may relate a case which occurred recently in my practice, where no source of the infection of scarlatina could be traced, but one of the cows on the farm suffered from ulcers on the teats.

The patient, W. K., a boy aged fourteen, lives with his parents on the farm of Fullwood head, in this parish. The farm-house is situated on a hill quite isolated from any other human dwelling, and built on one of the knolls of gravelly sands which surmount an extensive stratum of boulder clay. The boy had been attending school until Monday, October 14th, when he complained of illness. I was called to see him on the morning of the 16th, when I found him covered with the characteristic rash of scarlet fever, the throat, temperature, etc., confirming the diagnosis of a typical case. As I knew of no other case of scarlatina in the district, and could find no history of exposure on the part of the boy to any infection, I naturally asked if there was any case of illness among the cows. The boy's mother told me that the cow which supplied them with milk had very sore teats for nearly a fortnight, but she applied lard to them, and they were now getting better; that the cow seemed ill and feverish for some days; and that a calf (not suckled) with the cow's milk had been purging for a few days, and not taking his milk as usual.

I examined both the cow and calf. The cow, I was told, gave birth to a dead calf some months ago, and the calf fed with her milk was six weeks old. On all the cow's teats there were ulcers, none in less of an oval shape and in size varying from five to fifteen millimeters

in length, and the width of about three quarters of their length, the edges well defined. The largest ulcer was on one of the hind teats near its base. There were from two to four ulcers on each teat, and also one covered with a scale and almost healed on the udder between the two right teats. I could find no affection of the cow's integument, and the calf appeared by this time to be in a healthy condition.

The boy was isolated as far as circumstances would permit, the drinking of the cow's milk discontinued, and there is as yet no appearance of the infection spreading to two other members of the family, one older and the other younger than the patient, who never had scarlatina.

The question then that suggests itself is: Can there be any relation between the bovine and the human disease in this case? There is no history of a previous case of scarlet fever, no clue to the exposure of the boy to any infection, the milk supply was from the cow with the sore teats, none of the milk from this cow being sold. The water supply is from a shallow well sunk in the sand near the house, and the disposal of sewage by the dunghill for application to land. It is possible that some of the children from other parishes who were attending school with the boy might have carried the specific poison to school; but the fact that only the boy in question caught the disease in a school with over one hundred and seventy pupils renders such a supposition highly improbable. It appears, therefore, that the only etiological factor remaining is the disease of the cow. In the absence of any experiment as to whether the cow suffered from the so-called "Hendon disease," which, according to Klein, is due to the streptococcus scarlatinae, the same micro-organism as is invariably found in the blood of patients with human scarlatina, we can not be sure of a direct relation of cause and effect in this case, but the facts mentioned I consider are at any rate sufficient to warrant a suspicion in that direction.—*Dr. C. R. Macdonald, British Med. Journal.*

**SALICYLIC ACID IN TYPHOID FEVER.**—*Dr. Schakovski (Thera. Monatsh.)* claims great success from the use of salicylic acid in malignant scarlatina. He has used it in one hundred and twenty-five cases. The mortality is but  $3\frac{1}{2}$  per cent. The following formula was used:

Acidi salicylici..... 1 part.  
Aque destillatæ ..... 75 parts.  
Syr. aurantii cort..... 30 parts.

M. Sig: Give teaspoonful every hour during the day, and every two hours during the night.

The temperature falls very rapidly after taking this mixture, so that in certain cases, inside

of forty-eight hours the temperature has fallen from  $105.8^{\circ}$  F. to  $100.4^{\circ}$  F. All trace of fever vanishes by the tenth day. Nevertheless the author advises the continuance of the remedy for some time, in decreasing doses, to prevent a relapse. All serious complications, such as uremia, anasarca, and diphtheria, are avoided through this treatment. The treatment is ineffectual only when employed too late (after the fourth day of illness), or where grave complications already exist.—*Medical Standard.*

**RECURRENT CHANCER.**—*Mr. H.* contracted a chancre early in 1888, and was treated for it by a London surgeon, who mercurialized him to salivation, applied nitric acid several times to the sore, and gave the patient lunar caustic to touch it with. The seat of the sore was at the free edge of the prepuce, on the dorsal aspect, half an inch to the right of the median line. He had also congenital phimosis.

In June of the same year he consulted me. He was then anemic, had lost much flesh, had sore throat and severe pain in the limbs, and his hair was falling out; there was no rash on the skin. At the sight of the sore was a slight cicatrix, and in the left groin a gland was enlarged and threatened to suppurate. He was told to rest, given mercury in small doses, and glycerinum belladonnæ to paint over the gland, which, however, suppurated, but soon healed. He improved rapidly under treatment and was soon well. He was recommended to continue the mercury for at least six months, which he did, leaving it off at Christmas, when he felt quite well. In January, 1889, a large abscess formed in the left groin, which burst and healed; being in the South, I did not see him at this time. Soon after this a sore began to form exactly on the site of the old one. In March he came to me again, when the sore was found to be a raised and well-defined induration, ulcerated on the smooth surface and secreting a thin, watery discharge. A gland was enlarged and hard in the right groin. Mercury internally and the usual applications did no good, doubtless owing to the stretching of the phimosed prepuce at each act of micturition and the irritation of the urine. He felt quite well and had no other symptoms. Circumcision at once removed the "recurrent" chancre, and cured him of his phimosis. That the second sore was not due to a fresh infection is proved by his absolute denial of fresh exposure, and to the fact of its not being followed by any other symptoms of syphilis.—*Dr. William Robinson, British Med. Journal.*

# The American Practitioner and News

"NEC TENUI PENNA."

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D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } - - - Editors.

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## SOME LIGHT ON THE THERAPEUTICS OF ASTHMA.

In the opinion of the British Medical Journal, a paper presented by Dr. Silva Nunes, of Rio, to the Brazilian Congress of Medicine and Surgery last year, contains a therapeutic truth that promises comfort if not cure to the grand army of asthmatics.

This observer claims that the far-famed lobelia inflata relieves the spasmodic dyspnea of asthma, not through the action of nauseant and emetic principles resident in the drug, but by virtue of an alkaloid, called lobeline, which antagonizes the spasm without producing either nausea or vomiting.

In the opinion of Dr. Nunes, the tincture of lobelia should never be used in the treatment of asthma, since alcohol extracts the emetic principle, which in effective doses induces such nausea, vomiting, and cerebral and cardiac depression as to make the patient miserable at best, while at times the effects become continuous and place his life in jeopardy.

Under the alkaloid the dyspnea of asthma vanishes like magic, and no nausea or depression is felt. The action is evanescent but effective, and the drug is rapidly eliminated from the system. It may be prescribed by hypodermic injection, in pill, or to children in syrup. The dose is variable, and pushed according to the urgency of the symptoms to be relieved.

It has varied in Dr. Nunes' practice from  $\frac{1}{4}$  of a grain to about 6 grains. It is best to begin with the minimum dose ( $\frac{1}{4}$  of a grain) in every case. In the cases recorded by the author, from 3 to 4 grains were given in the course of twenty-four hours.

"The cases recorded are simple, uncomplicated asthma, or bronchitic asthma; in some the asthma was associated with bronchitis. In recording results in the treatment of asthma, it would seem a mistake to speak of the paroxysms of dyspnea occurring in bronchitis and emphysema as a form of asthma; such terms, indeed, as 'bronchitic' asthma and 'cardiac' asthma ought to be discarded from the medical vocabulary, and the term asthma limited to the spasmodic dyspnea which is associated with various neuroses, and is itself a neurosis. From Dr. Nunes' record of cases he seems to have obtained excellent results with lobeline in the treatment of spasmodic asthma and of bronchitic dyspnea. He places his observation before the medical public with a view of obtaining a fair trial of the alkaloid. Cases of asthma appear permanently relieved many months after taking the lobeline."

Of course this new drug, like all new drugs vaunted as cures for incurable diseases, is worthy of trial. The therapeutic conservative, however, will waste no enthusiasm upon the alleged discovery until a long list of favorable returns shall be authoritatively placed on file.

If, however, the temporary good which has hitherto been gotten from lobelia in asthma can be had through the new alkaloid without nausea, vomiting, or depression, it will prove a boon to suffering humanity.

GLAD TO ACKNOWLEDGE THE SOURCE.—The following from our esteemed contemporary, the editor of the Medical Age, explains itself: "I have read with interest your editorial in the November 9th number of the American Practitioner and News, entitled 'What has Become of the Elixir Vita?' and inasmuch as you state therein that you do not know the source of the paragraph you quote regarding spermine, I beg to refer you to the August 26th number of the Medical Age, pages 369 and 372. I am glad to see the medical press defend Brown Sequard after the vituperation heaped upon him and his discoveries by the popular press."

## Notes and Queries.

**MEDICINE IN INDIANA FIFTY YEARS AGO.**—Dr. Wm. H. Wishard, President of the Indiana Medical Society (meeting of 1889), chose, as the subject of the annual address, a Medical Retrospect of Fifty Years.

The first settlements were made along the water-courses, the land was very fertile and easily tilled, and we looked forward to our autumnal sickness as much as we did to seed-time and harvest, and the prudent man prepared for it by doing his work in advance, and by laying in his supply of medicine, which usually consisted of tartar emetic, calomel, rhubarb, aloes, or jalap, and epsom salts or castor oil.

It was not expected that a physician would be called until the resources of the neighbors were exhausted. Every neighborhood had some one who could bleed, extract teeth, and "dose out doctor's medicine," as they called it; also some old aunt who treated the women and children, and she had a list of domestic remedies that she obtained from the forest and garden. When she spoke of their virtues and adaptation to the various diseases of her specialties, the doctor that failed to know as much about her remedial agents as she did was no doctor, in her estimation. Although she was a strange compound of superstition, ignorance, and wisdom, her influence was marked. The early settlers were exempt from some of the most formidable diseases we now have to combat, notably, tuberculosis, diphtheria and cerebro-spinal meningitis. None but the strong and vigorous ventured to the frontier, knowing the hardships that awaited them, and as a class they were free from any constitutional diseases. Their mode of living in log cabins with open fire-places and a good supply of oxygen, and their plain and nutritious diet were well calculated to counteract any tubercular tendency.

Diphtheria as a distinctive disease was unknown to the early practitioners. Eberle's Practice, published as late as 1845, gives no account of the disease.

Cerebro-spinal meningitis was equally a stranger, though it was not unusual to have a case of phrenitis, as it was called by the older authors, but now termed meningitis.

The various forms of fever produced by miasma, malaria, or marsh miasmata, as it was called by different authors, were multitudinous, from the shaking-ague chill and fever, or intermittent, to the various types with remittent congestive and pernicious intermittent and congestive.

Authors differed somewhat in their classification, but they were all recognized as autumnal diseases. In the winter season pleurisy and pneumonia prevailed, often complicated with hepatic disorders.

There was a disease called quick consumption, the sequel of repeated attacks of pneumonia or pleurisy breaking down the lung tissue.

This was a fruitful field for quack doctors to try their hand in curing consumption.

But few cases of intermittent fever were treated by the doctors. It was only in the persistent forms of remittent and congestive fever where medical aid was summoned, and then not until family medication had been exhausted by taking the patient through a course of emetics, bleeding, and cathartics. Unless it was a case well marked of congestive or pernicious fever, the doctor was not called until the fifth or sixth day, after the patient had been treated vigorously by the three great depletory processes, emetics, cathartics, and blood-letting. The exhausted condition of the patient, or, possibly, the intestinal disturbance caused by the too free use of cathartics, would produce a condition which would demand the use of opiates and blisters by the physician, and the last state of that patient was worse than the first. The principal business of the doctor was dealing in second-hand goods, and a bad quality at that.

For a patient to consult a physician when he was first taken ill was an anomaly in medicine, and a useless expenditure of time and money. Four fifths of the fatal cases were second-hand, but the doctor was responsible for the result, as he had the last chance.

I will not go into details in treating the remittent fevers. A favorite prescription was "ten and ten" as a purgative, ten grains calomel, ten grains jalap, given every six hours until it produced free purgation; then the dose was lessened, but continued until it produced slight ptialism. If the case was of an inflammatory type, nauseating doses of tartar emetic were given to reduce the fever. If it produced watery stools, the bowels were restrained with laudanum or opium.

They gave, to reduce fever, sweet spirits niter or nitrate of potash. Cold water was prohibited. The maxim was, feed a cold and starve a fever. The tonics consisted of Peruvian bark, Huxham's tincture of bark, or an infusion of quassia. Tonics were always withheld until the fever was broken.

Quinine was rarely used, and was considered an uncertain and unsafe article. I remember well the first time it was used in my father's family, in the autumn of 1828. We were suffering with malarial fever, and had used about half a pound of Peruvian bark, and bitters of every kind and quality known, yet the chills would return every seventh or fourteenth day. My father sent me to Indianapolis to a physician to get medicine to prevent the relapse of the chills. The prescription consisted of thirty grains quinine, ten drops sulphuric acid, and six ounces water; dose, one teaspoonful three or four times a day, to be taken with great care.

Blood-letting was an indispensable remedial agent, and when wisely used by an intelligent physician was a power for good, and saved many valuable lives. It was only used in certain forms of intermittent and congestive fevers. In the first stages of pleurisy and pneumonia it was the sheet anchor, followed with judicious medication.

I admit that the laity bled indiscriminately and unwisely, making no distinction. Fever was fever; and if it was good in one case, why was it not good in all cases?

I have seen an old thumb lancet that was an heir-loom in the family. It had drawn blood from the grandfather and father, and

was now doing duty for the grandchildren. That one instrument had drawn more blood than was spilt by some regiments in the late war. It was not unusual for many persons to be bled every spring. They had the superstitious belief that their blood was too thick, and that the old blood had to be drawn off to give room for a new and better article.

I have seen arms so scarred by repeated bleeding that you could scarcely locate the vein to bleed in. Another superstitious notion that possessed the laity was, that if you bled a patient in the right arm when the pain was in the left side it would draw the pain across his heart, and death would be the result sooner or later.

The physician that made such a mistake was taking an unwarranted risk; and, should the patient die, he was held responsible for his death.

The author speaks of Dr. L. P. Yandell, Sr., in connection with the management of malarial fever in the following terms.

By 1840 great improvement was made in the treatment of fevers. Quinine was used more extensively in intermittent fever, but not in remittent. In 1841 the State Medical Society of Tennessee offered a prize of one hundred dollars for the best essay on the treatment of fevers. It was awarded to Dr. Lunsford P. Yandell, Professor of Chemistry in the University of Louisville, and published in the *Western Medical Journal* of that city. I was taking that journal, and read and re-read his article. He recommended the abortive treatment of bilious fever by the use of a cathartic or an emeto-cathartic, and the free use of water; sponging the patient during the hot stages, diuretics and diaphoretics, and the early administration of quinine and Dover's powder during the remission. It was a complete departure from the old doctrine of wearing out the fever, and his reasoning was so common-sense and well-founded that the younger men of the profession accepted it gladly, but the older men shook their heads and denounced it as a dangerous innovation on established principles in medicine.

It soon, however, became the accepted mode of treatment by the progressive men in the profession, and those who opposed it gradually fell into line, until ultimately they all agreed. When I look back on the last half century, I can think of no one man who has done so much for the treatment of fever as the late lamented Professor Lunsford P. Yandell. He lifted the curtain which let in the light that has been shining brighter and brighter to the present day.

*Editors American Practitioner and News:*

OBSTETRICS AND GYNECOLOGY.—The treatment of abortion is a subject of great importance because it is one which is always with us, and the careful handling of the case often saves the patient from long and troublesome, as well as dangerous sickness. Of great interest to me is a case which happened recently in my practice. I was called to see a woman who was seven months pregnant with her third child. She was suffering from pains and seemed to be on the verge of aborting. I prescribed dioviburnia, made by the Dios Chemical Company, of St. Louis, in doses of a dessertspoonful four times a day. The threatened abortion passed off, and I was not again sent for until a month elapsed, when I found her in the same condition as before, suffering very much pain. She begged me for the medicine which had done her so much good on a former occasion, and I gave it to her in the same dose with a like result. On delivering her at full term of a fine boy, she volunteered the confession that she had on both the occasions mentioned made desperate efforts to produce an abortion, and only sent for me when her sufferings became unbearable. I have also had marked results from this remedy in other cases, but the one here presented is of the most interest. I shall further continue its use.

The Treatment of Endometritis was the subject recently taken up before the French Academy of Medicine by M. Dumont Pallier. His report embraced one hundred and twenty cases, and his treatment had been to place a pencil of the chloride of zinc paste in the uterus at the patient's residence, preceding and following this application by an

antiseptic injection. The cavity of the uterus is first measured by the sound, and the pencil of caustic made the proper length to reach from the fundus to the cervix. It is held in place by an iodoform gauze. If hemorrhage accompanies the endometritis this agent checks it at once. The pain is variable in amount, and the slough which forms detaches itself in from four to thirteen days, and in two days after the cure is complete. The menses return at the usual periods and cause no pain.

"The Perineum" is the short, broad subject of a thirty-one page brochure, with ten well-executed plates, by Henry O. Marcy, of Boston. After a lengthy discussion of the subject, and establishing his claim to priority in the use of the buried animal sutures, he closes with a minute description of his method of operating, which differs from others in the following particulars: The posterior third of the vagina, not its mucous membrane, is dissected from its vulvar attachment, and is carried, as deemed necessary, into the recto-vaginal space, and this flap is retained. In those cases where there is rectocele with prolapse he closes the deep layers of the post-vaginal fascia with a continuous buried animal suture, taken either in single or double stitch. By lifting forward the vagina from its vulvar attachment, the retracted transverse perineal muscles with their connections can be reached and closed also by a deep buried suture, making in its way a true restoration of the pelvic floor; by coapting all superficial surfaces by a buried animal suture applied in a blind continuous stitch from side to side, covering the same when dry with iodoform colloidion; the application of lateral supports, pins external to the sutures as a splint, to hold the parts in complete apposition without strain. In complete ruptures, the lateral dissection, the joining of the rectal and the vaginal edges with buried sutures, and then finishing the operation as in incomplete ruptures.

Menthol in the vomiting of pregnancy is highly recommended by Gottschalk, of Berlin, in the *Berliner Klinische Wochenschrift*. He used menthol 1 part, alcohol 20 parts, water 150 parts. One teaspoonful every hour. The case reported was a very obstinate one, and was promptly controlled by the remedy.

*Hydrastis canadensis* in contractions of the uterus, according to Schatz, of Rostock (*Berliner Klinische Wochenschrift*), does not produce contractions. It has solely a vaso-motor action, evidenced by the contraction of vessels and the induction of anemia in the organs of the genital system as well as in the other viscera of the abdomen.

Dr. James R. Chadwick, of Boston, conceived, and Dr. Fordyce Baker, of New York, generated the American Gynecological Society.

Dr. H. P. C. Wilson, of Baltimore, in his presidential address before the American Gynecological Society, was not very friendly toward the new complications into which the Society is becoming entangled with the American Congress of Physicians and Surgeons. He said: "I would restrain this Society from all entangling alliances with other societies. The distractions of such large assemblies are not promotive of the best work in any specialty. If we would make it the great authority on gynecological subjects, if we would make it the first in wisdom as the first in age, we must abstain from too much allegiance to other societies and let our full strength be concentrated here. Whatever time and labor we spend with them will be subtracted from this, and by so much will its vigor and strength be diminished."

Laparotomy During Menstruation was the subject of the scientific portion of the address of the president of the American Gynecological Society, Dr. H. P. C. Wilson, of Baltimore, at the meeting held in Boston in September, 1889. Shall laparotomy be performed immediately preceding or during menstruation? was a subject which frequently embarrassed him during his earlier professional career. His experience had taught him that for laparotomies involving the pelvic organs it was better to select the uterine flood than the uterine ebb. During the uterine flood the circulation and innervation are in a state of tonic excitement. During the uterine ebb they are in a state of relaxation and depression. On this account patients are more liable to passive hemorrhages, the absorption of septic poison, the deadly influence of shock, than when the system is under the stimulus of the uterine flood. It

might be said that inflammatory troubles are more apt to be set up during the uterine flood, yet he could not recall that he had lost a case of laparotomy by inflammation other than septic. The doctor related two cases in detail in which he had performed laparotomy for ovariotomy during menstruation, which came on owing to the excitement of the patient in anticipation of the operation. He said he could relate many cases in which he had performed laparotomy very near or during menstruation, but would not detain the Society. Within the past year he had done a number of such operations, and every one recovered. He has not lost a case where laparotomy was done immediately before or during menstruation, and he is forced to make the uterine flood the time of selection for such operations rather than the uterine ebb.

The Cincinnati Obstetrical Society held its October meeting at the residence of Dr. E. S. McKee. The paper of the evening was read by Dr. E. W. Mitchell on the subject, The Medical Treatment of Dysmenorrhea. The doctor handled his subject in a very able manner, and showed an acquaintance with both the theoretical and practical sides which was very great. It would be impossible to give a fair synopsis of the paper and the instructive case reports which it contained. The doctor had gained considerable relief from the use of anti-pyrine, but failed to attain a permanent cure. Apiol had given satisfaction in his hands. The hygiene of the young girl was a much neglected and very important subject. The paper was fully discussed by the members of the Society, and some remarks of special value made by Dr. C. D. Palmer. Concentrated tincture of cimicifuga in moderate doses for a few days prior to the period, and at frequent intervals during the pain, also the tincture of pulsatilla, had done him good service. He advised the building up of the general health in every possible way.

E. S. MCKEE, M. D.

CINCINNATI, O.

TUBERCULOSIS IN SLEEPING CARS.—The recently acquired knowledge of the tubercle bacillus, and of the dangerous properties of the dried sputa of tuberculous subjects is

causing a gradual revision of the views hitherto obtaining in regard to many of the adjuncts and accessories of our modern civilization. We referred last week to the rehabilitation of the spittoon by the bacillus, and it seems possible that the same microbe may, on the other hand, destroy the character of the much-vaunted American sleeping-car.

At a recent meeting of the Surgeons' Association of one of the great railroad systems, Dr. J. T. Whittaker, of Cincinnati, made some remarks, by invitation, on "Tuberculosis in Sleeping-Cars," which are calculated to startle the traveling public, but which the physician can not deny are not without considerable justification in the actual condition to which the traveling public (and in the United States that means the great majority of the well-to-do population) is constantly exposed.

It is startling to have to accept, but it is hard to dissent from, the following statements:

"It would be difficult to conceive of a conjunction of circumstances more directly contributive to disseminate this disease (tuberculosis) than is offered in the palace car. It is always badly ventilated; the vestibule-car especially is close and hot, sixteen to thirty people being crowded into a space that might make a small hall in a house, but never a bed-room for a pair of human beings. Somebody is always hurt by a draught, so that windows are kept closed to prevent free ventilation, as well as the ejection of sputum, which is mostly deposited on the floors. Cuspidors never contain water, and are mostly used as waste baskets or slop jars, and the temperature is raised to a degree sufficient to rapidly disseminate infectious matter.

"With the gathering shades of evening the compartments containing the bedding are opened into the car to diffuse through it a disagreeable, musty odor. The traveler is treated to the luxury visibly of clean sheets and pillow-cases, but the blankets, mattresses, carpets, and, worst of all, the curtains, remain the same until worn out.

"Consider now that every car contains or

has recently been occupied by a consumptive traveler, if only *en route* for change of climate, and that through ignorance, carelessness, or weakness there comes to be deposited upon curtains, bedding, etc., tuberculous matter. What becomes of it, if it be not dried and disseminated throughout the car or gradually incorporated into the lungs of the traveler?"

The traveler on the express trains, Dr. Whittaker suggests, is in the condition of the dogs made to breathe, inclosed in boxes, of atomized tuberculous matter until even they, naturally immune, became infected with the disease. The danger to ocean voyagers is less, in that they are likely to be more in the fresh air which offsets the closer confinement in the still more restricted cabins and the ordinarily greater length of the voyage.

But the public having once enjoyed its comfort can not be asked to forego the sleeping-car, any more than the public can be asked to give up eating beef and drinking milk lest tuberculosis enter the system and take up its abode. What means are there to ward off or mitigate its dangers short of banishing the sleeping-car altogether?

It is suggested, and we wish the suggestion might meet with a practical response, "that the plush, velvet, and silk hangings must go. Seats should be covered with smooth leather, that may be washed off; carpets replaced by rugs, to be shaken in the open air at the end of every trip, or, better still, abolished for hard wood floors. The curtain abomination must give place to screens of wood or leather, blankets of invalid's beds be subjected to steam at a high temperature, mattresses be covered with oiled silk or rubber cloth, that may be washed off; and, above all things, invalids must be provided with separate compartments, shut off from the rest of the car with the same care taken to shut out the far less offensive or dangerous smoke of tobacco. The cuspidors, half filled with water, should abound (as they now abound) in every car, and consumptive travelers be provided with

sputum cups, which may be emptied from the ear. For it is not necessary to say here that the sole and only danger lies in the sputum. The destruction of the sputum abolishes the disease. When the patient himself learns that he protects himself in this way as much as others, protects himself from auto-infection, from the infection of sound parts of his own lungs, he will not protest against such measures."

In the mental exhilaration consequent upon existing discoveries in regard to the tubercle bacillus it is not well that we should permit our still undeveloped knowledge to beget precocious fears and panics. It should not be forgotten that the soil, as well as the seed, is necessary for the crop; that the healthy system knows how to protect itself against even this formidable enemy. But this cry of warning should not go unheeded. How many tuberculous invalids travel to and from the South every winter and spring, and how many non-tuberculous but enfeebled people along with them! To point out that such are exposed on the fast through trains to especial dangers, dangers which can be diminished and should be minimized—this is not to be an alarmist.—*Boston Medical and Surgical Journal*.

**OBITUARY—PHILIPPE RICORD.**—Dr. Philippe Ricord, the celebrated teacher of venereal disease and syphilography, died in Paris October 22, 1889, at the age of eighty-nine years.

Though Dr. Ricord was accounted a French physician and was a member of the Academy of Medicine, he was born in Baltimore. He was the grandson of a distinguished physician of Marseilles, and a brother of J. B. Ricord, the author of works on language, medicine, and natural history, many of which were first published in this country. Under this brother he made a number of scientific studies, and began the study of medicine in Philadelphia. In 1820 he went to Paris. He was admitted to the study of surgery, first at the Hôtel Dieu under Dupuytren, then at the Pitié under Lisfranc, receiving the degree of Doctor of

Medicine in 1826. In 1828 he delivered a course of lectures on surgery in Paris, and in 1831 he was appointed Surgeon-in-chief to the Venereal Hospital of the Mall. At this hospital, from which he retired on account of age in 1860, he gained a great reputation as a syphilographer. By a decree bearing date July 28, 1862, he was appointed physician in ordinary to Prince Napoleon, and on October 26, 1869, was named consulting surgeon to Napoleon III. He became a Commander of the Legion of Honor, and in 1871 was made a Grand Officer for services during the siege of Paris. He also received many foreign decorations. He has been an active writer, several of his works on surgery having been crowned by the Academy of Sciences. For many years he was known in Paris as "the great American doctor," and he has always had a warm interest in his native land. Ricord leaves a name never to be forgotten in the history of syphilography and during the active years of his life he was the most famous specialist in his line in the world.—*Medical and Surgical Reporter*.

**M. RICORD'S FUNERAL.**—The Paris correspondent of the *British Medical Journal* writes: "Professor Ricord's funeral took place on Saturday, October 26th. It was an imposing ceremony. The coffin and bier appeared buried under the enormous quantity of wreaths placed on them, bearing testimony to the personal esteem he won during lifetime; and the military honors rendered to the deceased were evidence of the worldly distinction he had attained during his professional career. M. Péan spoke in the name of the Academy of Medicine, and M. Fournier represented the pupils of the late distinguished professor.

A RATHER unusual bill in equity was filed in the Court of Common Pleas in Harrisburg, Penn., recently. Dr. W. M. Frost, the complainant, sets forth in the bill that he was a physician in good standing in Baltimore, where he had a good practice, and held also the chair of Diseases of Children

in the Baltimore Polyclinic and Post-Graduate Medical College; that during last May he came to Harrisburg on a visit to his parents, and while here met Dr. John L. Seitz, of Ridge Avenue; that the latter stated he was going to remove permanently to Columbus, O., and would not return to Harrisburg to practice medicine; that the complainant entered into an agreement for the purchase of Dr. Seitz's practice; that the consideration was \$50, half of which was paid in cash and the other half by a note payable in ninety days.

Dr. Frost further states that he abandoned his practice in Baltimore and came to Harrisburg in June, and immediately began practicing medicine in the families that Dr. Seitz had introduced and transferred to him. Dr. Seitz returned from Columbus in August, and again began the practice of his profession in the vicinity of his former office. Dr. Frost says he would not have abandoned his Baltimore practice if Seitz had not made the agreement in question, and that he had suffered loss. October 14th is fixed by the court as the time for hearing the motion to continue the preliminary injunction.—*Boston Medical and Surgical Journal*.

THE Boston Post says that there are 3,000 medical women in the United States whose incomes range from \$5,000 to \$20,000 a year. The number is increasing every year, and the supply of "lady doctors" bids fair to be as great as that of the male physicians. Austria is the only civilized country in the world which prohibits women from entering the medical profession. Russia and China permit them, and the queens of Italy and Roumania employ women physicians.

JOHNSTOWN, PA., was free from typhoid fever October 16th, and, on the authority of the Red Cross Association, may be considered fairly safe from danger for the present season.

DR. MAURICE PERRIN, President of the Academy of Medicine at Paris, died recently.

THE freshest ailment is an affection of the fingers due to constantly thumping a typewriter.

### SPECIAL NOTICES.

PARIS EXHIBITION.—W. R. Warner & Co. have received a silver medal at the Paris World's Fair, being the highest of its kind, in recognition of the following claims:

*First.* W. R. Warner & Co.'s Pills, quick solubility and accuracy.

*Second.* Reliability and permanency unsurpassed.

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*First.* Superior effervescing properties.

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This is the 13th World's Fair Medal which attests to their superiority. Physicians should be careful to specify Warner & Co.

I have used in my practice the preparation known as "Succus Alterans," and have much pleasure in bearing testimony to its great value.

For diseases having their origin in a syphilitic source, I believe the Succus to be the one reliable specific, for I may add that invariably success has been met with by me when prescribing the remedy in question, even after the failure of other alteratives. I shall continue to rely on the Succus in all cases I have indicated herein.

Yours truly, WM. RD. GOODFELLOW,  
(Member Royal College Surgeons, I. S. A.)  
ROCHE, CORNWALL, ENG., MARCH 20, 1889.

J. E. PRICHARD, M. D., Baltimore, Md., says: The Aletris Cordial I think a most excellent remedy, and have used it in ten cases of suppressed menstruation, in all of which with the best results. Among my patients were four unmarried women; one, aged twenty years, had her menstruation arrested six months when she came under my care. She was swollen, and suffered considerable pain at each monthly period, but she had no show of any catamenial discharge. I placed her on Aletris Cordial, teaspoonful doses, three times a day. She continued it for seven days, when she menstruated. I ordered her to commence again five days before her expected time to menstruate, which she has done. She is now regular, and suffers no pain. Have also used it in cases of vaginal leucorrhea with a happy result. In cases of hysteria which we sometimes find complicated with leucorrhea I have combined it with Celerina:

Aletris Cordial.....4 ounces.

Celerina.....4 ounces.

M. Sig: Teaspoonful every three hours for one day, then the next would give it four to five hours.

I am happy to say that it has not failed to give relief in all cases in which I have prescribed it.

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÄ."

VOL. VIII.

LOUISVILLE, KY., DECEMBER 7, 1889

No. 12.

[NEW SERIES.]

*Certainly it is excellent discipline for an editor to feel that he must say all he has to say in the brief space of time, and his reader is sure to skip them, and in the process of passing on his reader will certainly misunderstand him. Generally a downright fact may be lost in a long story, and the most downright facts at present more than can be read.*

## Original Articles.

### TUMORS OF THE PHARYNX; TWO CASES.

BY W. CHEATHAM, M. D.

*Lecturer on Diseases of the Eye, Ear, Throat, and Nose,  
University of Louisville.*

Harry L., aged twelve, last March was found to have some disease of the post-nasal space. He saw Dr. S., of this city, who diagnosed a growth in that locality. He afterward saw Drs. Dabney and Ray, both of whom made the diagnosis of a growth in the naso-pharyngeal space. He came to see me in September, when I found a growth filling the post-nasal space. The growth pushed the soft palate well forward, making blowing or breathing through the nose impossible, with all the symptoms usual in post-nasal obstruction. His breathing at night was most distressing, he having to sleep with his mouth open, and, as such patients usually do, on his back. After a few respirations his tongue would fall back, choking him; he would awaken fighting for air, never getting any rest, and as a result had loss of appetite, loss of weight, anemia, etc. The little fellow presented a bad appearance; every feature expressed great distress.

September 29th: I was telephoned for hurriedly, the messenger saying that the boy was about to choke to death. The previous night had been one of great distress to him, he had had but few moments' sleep; his mouth was wide open and his breathing very labored. I advised that im-

mediate efforts be made to remove the obstruction, which appeared to be fibrous in its nature. Dr. D had previously made an effort at its removal, and succeeded in getting away quite a large piece with a scissor; the space was so compactly filled that I could get no wire around the growth, but by grasping the tumor with a volsella and pulling it well down I succeeded in removing quite a mass with scissors. I previously tried such forceps as are usually used in removing a tumor tissue from this same location; the growth would stretch, and the forceps would slip off, allowing the tumor to spring back like a large rubber band. The patient refused to take chloroform in any of the operations I performed on him. The throat was no doubt anesthetic from the pressure, scarcely any hemorrhage followed the operations, which surprised me very much, as many vessels could be discovered in the parts removed, and as the tissue was so hard I felt that the coats of the vessels could not contract. Scarcely any inflammation followed the operations.

October 5th, one week later, other efforts at the removal of the growth were made; a Douglas snare with a slightly curved end was passed through the nose, it meeting with great resistance as it entered the post-nasal space, going through some substance sounding as if it was a thin shell or bone. After much manipulating through the mouth the wire was finally passed around the tumor. After turning the screw for some time and making but little progress, I could see through the mouth that something was going wrong. The snare was removed, when I found the wire was cutting the snare into in two. The MacDouglas snare was then tried through the mouth, but the end of this snare

Read before the Louisville Surgical Society, October 11, 1889. For discussion see page 361.

was bent nearly double. I finally thought of using a tonsillotome, and by means of the Mathien instrument used through the mouth removed the mass presented to this Society to-night. This mass is only about one half the size of the original. In this last operation the volsella was also used to pull the growth down so the tonsillotome could be gotten around the growth. Those present no doubt will suggest the splitting of the soft palate so the growth can be gotten at easier, and the use of the galvo-cautery. If I can not succeed better next time without it I shall pursue the above course. The first piece removed was submitted to Dr. Simon Flexner for microscopical examination, who reports as follows:

"The tumor varies in different parts. That portion which I take to be the oldest is somewhat fibrous, while the larger part is almost purely sarcomatous. In the more fibrous portions are numerous connective tissue corpuscles, indicating great rapidity of growth. Here also may be found many spindle sarcomatous cells. It is difficult to state where one process ends and the other begins. The largest part of the growth is of the round-cell variety of sarcoma. Again, in the older portion I find numerous spots of recent hemorrhage, and on the surface a black discoloration and shriveled appearance of the cells in this locality. This latter is caused, in my opinion, by the use of astringents or caustics. In conclusion, the growth is a mixture of sarcoma and fibrosarcoma. Originally it may have been a rapidly proliferating fibroma, and the sarcomatous character have been developed later. The black discoloration and shriveled appearance of some of the cells was no doubt the result of previous surgical interference."

The prognosis is, of course, unfavorable.

CASE 2, in the person of Mr. S., aged sixty-seven, of Pittsburgh, Pa.; he presented himself October 10th. He had on the left side of his neck an adenitis as large as my double fist, nodulated, and very hard; this appeared first eight months ago. On the right side the adenitis was very small. Mr. S. sup-

posed he was suffering from some catarrhal inflammation of nose and throat; his respiration was entirely by the mouth; voice characteristic of such cases, and of itself diagnostic. He had not noticed any trouble with his throat but for four weeks, so the growth of the tumor must have been very rapid. The soft palate was pushed down and forward; with the finger I could feel a hard, firm mass filling the post-nasal space thoroughly; considerable bleeding followed this manipulation. The rhinoscope showed a roundish tumor, well covered with blood-vessels, presenting somewhat the appearance of an abscess; the growth appeared to have a broad base springing from the right side and the right half of the posterior wall of the pharynx. My advice to this gentleman was to return home at once. I sent his Pittsburgh physician a letter of advice, stating that in my opinion tracheotomy or laryngotomy should be performed at once, as he was liable to have edema of glottis from pressure, or from excessive dryness of the mucous membrane, the result of his breathing through his mouth constantly.

These are the only two cases of growths of the pharynx it has been my fortune to see (outside of tonsil hypertrophy), and they presented themselves inside of two weeks.

In looking up this subject of tumors of the pharynx, two things attracted my attention; one was the exceedingly small space given to the subject, and the second, which may account for the first, the extreme rarity of the affection.

Gross says it is very rare, and that the tumors are either fibroma, fibro-myoma, fibrous sarcoma, or lipoma.

Ashhurst's *Erichsen* says tumors of the naso-pharynx spring from the areolar tissue of the part, and are mostly cancerous, and that polypi, when truly pharyngeal, grow very rapidly and are malignant.

Bryant says they are cancerous and usually begin in the upper part of the pharynx.

Ashhurst, in the *International Encyclopedia of Surgery*, says they are rare, usually congenital, pendulous, with narrow necks.

The growth in the little boy's case, I forgot to say, springs from the upper right side of the pharynx, apparently with a long and rather narrow neck.

Wagner says "they grow with rapidity, and that they are more frequent in young persons; that they spring from periosteum or connective tissue; that polypi may occur at any age. Winter discovered one in a fetus of seven months. If in a subject beyond middle life, it is generally presumptive evidence of malignancy; that it is more common between fourteen and twenty-five; more common in males than in females. In fifty-eight cases collected, forty-eight were males, eight females, and in two the sex was not stated. Thirty-eight of these were genuine fibromata, all in males under twenty-years of age."

Mackenzie says such growths are decidedly rare; that the disease is probably due to an irregular evolution during the growing period of a tissue which under normal conditions is exceptionally abundant on the under surface of the base of the skull; that they may spring from any part of the roof or lateral walls of the naso-pharyngeal cavity; that Nélaton says that the primary point of origin is, in all cases, the periosteum, covering a limited area on the under surface of the base of the skull corresponding to the basilar process of the occipital, and the body of the sphenoid, bone; that any other points of attachment are secondary in the expansion of the growth. Mackenzie dealt quite extensively with fibrous polypi, fibro-mucous polypi, enchondroma and malignant tumors of the naso-pharynx. He has, in his most excellent book, by far the most extensive and comprehensive article on these subjects in print. He is as usual most thorough. In an article published in the Transactions of the Ninth International Medical Congress, several cases of death from hemorrhage are reported after the removal of the fibromata, and most of the books referring to this subject speak of the danger from hemorrhage in such cases. Most of the authors on this subject say such growths disappear of themselves at or about

the twenty-fifth year of age; that sometimes they slough off.

Holmes says: "Cancer of upper part of pharynx is exceedingly rare; that, out of eight thousand two hundred and eighty-nine deaths from cancer in the Paris registers, three were ascribed to cancer of the tonsils, and four to cancer of the pharynx.

LOUISVILLE.

## FIFTY APHORISMS ON THE POSITION OF THE HEART.

BY E. J. KEMPE, M. D.

This paper is limited to a description of the position of the heart in health and in disease.

*Normal Position.* 1. The heart is in the chest; it rests on the diaphragm, which separates it from the liver and stomach; it lies between the inner surfaces of the two lungs, which are hollowed out to receive it, it hangs suspended by the great blood-vessels.

2. The posterior surface, formed by part of the right auricle, the left auricle, and the left ventricle, is in relation with the contents of the posterior mediastinum.

3. The anterior part is partly covered by the lungs. A space is left uncovered, corresponding to the center of the sternum, opposite the fourth costo-sternal articulation. A line drawn from the fourth costo-sternal articulation downward, with an outward curve to the apex of the heart, and another to the lower end of the gladiolus, makes the triangular space of absolute cardiac dullness. Here the heart lies in apposition to the chest wall, and a dull note is elicited by percussing the triangular space.

4. The position of the heart is affected by posture of the body; for instance, by leaning forward the organ presses against the chest wall, and in the recumbent position of the body the heart recedes from the chest wall.

5. Its position is also changed by the heart's own motions, systole and diastole; by the action of the lungs in respiration, and by the movements of the muscles of respiration.

6. To the clinician these momentary changes are of some practical interest, and he should bear them in mind. In some cases the patient must lean forward, and thus help us make out the apex beat of the heart; at other times other postures of the patient are desirable for various reasons.

7. To map out the normal position of the heart at the front, we draw a line on a level with the upper edges of the third costal cartilages; another line on a level with the articulation of the ensiform cartilage and the interspace between the fifth and sixth costal cartilages; then we draw a vertical line one half inch to the right of the sternum, and another vertical line one inch to the left of the sternum. Into this space—a square with the angles lopped off—we can imagine a heart about the size of the patient's shut fist, which, on the average, would be five inches long, three inches wide, and two and a half inches thick from before backward. This heart lies obliquely, the base to the right and the apex to the left.

8. The base of the heart corresponds to the interval between the fifth and eighth dorsal vertebræ.

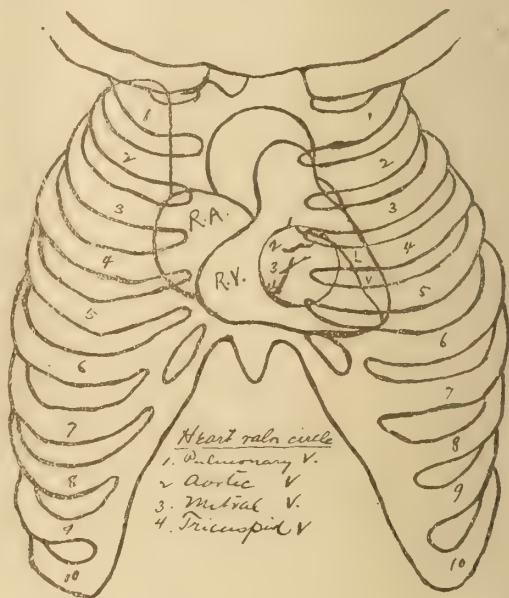
9. The apex is found one inch to the right and three inches below the nipple, a little below the fifth rib. The heart-beat represents to the examiner the apex of the heart. It may be covered by the tip of one's finger.

10. In women with a large, flabby mamma, whose nipple is at no particular point, it is a good idea to take a rule and draw a vertical line down the center of the sternum, and from this line measure two inches outward in the interspace between the fifth and sixth ribs on the left side, and there the apex-beat ought to be found.

11. In listening for aortic sounds the doctor puts his ear to the second right interspace, for the pulmonary valve sounds at the second left interspace. For mitral valve troubles he listens to the apex, and for tricuspid valve derangements he listens at the fourth interspace near the sternum. He does this because troublous sounds at the valves named are to be heard plainest at

those points, although the valves are not situated there.

12. By drawing a circle over a space corresponding to the lower edge of the third left costal cartilage, the lower edge of the fifth left costal cartilage, the central line of the sternum, with the center of the circle at the left edge of the sternum, he has encircled the heart valves. (The figure shows the circle, which, by the way, is original.)



13. The pulmonary semi-lunar valves lie behind the upper edge of the third left costal cartilage. They cover the aortic valves.

14. The valves of the aorta are under the lower edge of the third left costal cartilage.

15. The tricuspid valve is found in the center of the chest opposite the fourth chondro-sternal articulation. It covers the mitral valve.

16. The mitral valve lies in the third left interspace, one inch from the sternum.

17. The lung overlaps the heart partly in front, completely on the side, and partly at the back, which is to be remembered in per-cussing the heart.

18. To map out the heart on the side of the chest, draw a line from the junction of the ensiform cartilage and sternum along the upper edge of the sixth costal cartilage to the upper edge of the tenth dorsal verte-

bra, and you have a platform on which the heart rests. A line along the lower edge of the second costal cartilage to the lower edge of the body of the third dorsal vertebra represents the upper border of the heart.

19. To map out the heart at the back, draw a horizontal line along the lower edge of the third dorsal and another line along the upper edge of the tenth dorsal vertebra, and the heart may be imagined in that space.

20. The right auricle is hidden by the anterior margin of the right lung. By passing a knife through the sternal ends of the third, fourth, and fifth costal cartilages, or the intervening spaces on the right side, we wound the right auricle. Its appendix is exactly behind the middle line, on a level with the upper border of the third costal cartilage.

21. The right ventricle extends from the third to the sixth costal cartilages on the left side, and occupies the chief part of the front of the heart. The margin of the right ventricle passes from the sternal end of the sixth right cartilage, and passes behind the seventh right cartilage, the ensiform cartilage, and the seventh left cartilage to meet the apex of the heart.

22. The left auricle is in relation with the esophagus and the contents of the posterior mediastinum. The pulmonary artery lies in front of it. The left auricle corresponds to the body of the eighth dorsal vertebra. Its apex is in the lower part of the second intercostal interspace, an inch and a quarter from the left of the sternum.

23. The left ventricle lies behind the right ventricle, except a rounded margin, which extends on the left side from the third costal cartilage to a point in the fifth interspace, two inches vertically below the nipple.

24. The auriculo-ventricular sulcus corresponds with a line drawn obliquely upward from near the sternal end of the sixth costal cartilage of the right side to the third cartilage on the left.

*Abnormal Positions.* Having briefly outlined the natural position of the heart, I will try to describe some of its abnormal positions or displacements:

25. The heart may be pushed up or down, to the left or to the right, to the front or to the back, by diseased conditions of the surrounding parts.

26. Effusion into the pericardium may enlarge the area of heart-dullness considerably.

27. A hypertrophied condition of the right ventricle enlarges the area assigned to the normal heart toward the left.

28. A hypertrophied condition of the left ventricle enlarges the area assigned to the normal heart to the left, and lowers its apex.

29. In children the relation of the heart to the chest walls is high.

30. In women, who lace, the lower boundary of the heart may be higher than normal.

31. In feeble persons who lead a sedentary life the heart-beat may be higher in position than the fifth interspace without being abnormal.

32. In robust, hard-working persons, the amount of reserved air in the lungs is great, the chest is high, deep, and broad, the heart is large, and the apex-beat may be an inch lower down than ordinary, and yet this position is not abnormal.

*Upward Displacements.* 33. Abdominal enlargements from ascites, gastro-intestinal distension, abdominal tumors, ovarian dropsy, aneurism of the abdominal aorta at the celiac axis, an enlarged liver and spleen, certain mediastinal tumors, all tend to raise the heart.

34. Intestinal distension from peritonitis, abdominal distension by the escape of gas from the intestines, and abscess of the upper part of the right lobe of the liver may push the heart upward and toward the left side.

35. In any illness the heart may lessen in size, or in fatal hemorrhage the heart is reduced, and its position changed upward.

*Downward Displacements.* 36. In emphysema the descent of the diaphragm brings about a downward displacement of the heart. The right side of the heart is invariably enlarged, and the lung nearly overlaps the heart.

37. In severe bronchitis the diaphragm is lowered, and the beat of the right ventricle may be seen in the epigastrium.

38. The same condition of things occurs in spasmodic asthma, in croup, in laryngitis, in laryngismus stridulus, and in collapse of the stomach and intestines.

39. Mediastinal tumors and pleuritic effusion of the left side may push the heart downward.

40. An aortic aneurism will displace the heart downward and to the right.

41. When the abdomen is flaccid from some reason or other, the heart drops downward.

42. In pneumonia, or in affections of a like nature, the heart is charged with blood and occupies a low position.

*Lateral Displacements.* 43. A diaphragmatic hernia may squeeze its way into the thorax and push the heart to the right or to the left.

44. In cirrhosis, or shrinkage of the left lung, the heart will be displaced to the left, and in cirrhosis of the right lung to the right.

45. Pleuritic effusions will push the heart to the opposite side.

46. Empyema, pneumo-thorax of one side of the chest, hemorrhage into either cavity of the chest, thoracic tumors, aneurism of the aorta, large abscesses, hydatid cysts or tumors of the upper part of the liver tend to displace the heart to opposite side of the chest from the affection.

*Comments.* 47. These displacements are valuable and decisive indications of disease by the evidence they afford us.

48. They cause functional disturbances of the heart by disturbing its action, causing palpitation and heart complaints.

49. They are more real than apparent, because the sternum and ribs, by means of which we map out the location of the heart, are generally also displaced by the same condition that displaces the heart.

50. The displacement of the heart in some instances may be so great that it is practically a dislocation.

## COMMON ERRORS IN REGARD TO ANOMALIES OF REFRACTION.\*

BY T. C. EVANS, M. D.

*Demonstrator of Anatomy in the Hospital College of Medicine,  
Visiting Surgeon to the Eye and Ear Department  
Louisville City Hospital.*

In presenting a paper on the Anomalies of Refraction, I wish to say in the beginning that I have no new facts to offer. I am well aware that the subject has been frequently discussed by able and thorough men, that the literature of the subject is quite comprehensive and leaves little to be desired; yet, notwithstanding all this, I am constrained to believe, from my short experience in this particular line of work, that the matter is almost universally misunderstood by the laity, and frequently, if not generally, by the profession. That the crude notions of the laity are but the reflection of the more technical but none the less erroneous opinions of the profession is apparent from the frequency with which we see able and prominent men in the profession certifying to the talismanic virtues of various kinds of pebble, quartz, or crystal spectacles, as sold by some itinerant vender whom they fancy to be endowed with some peculiar optical instinct. The editor of one of the leading medical monthlies certifies to the fact that he has had a troublesome error of refraction, not corrected, but entirely and permanently cured, so that he no longer finds it necessary to wear the "patent crystallizable spectacles" which changed the course of nature and wrought this wonderful cure. Though this miracle was performed in one of the smaller cities of the Southwest, this obliging Nicodemus has generously permitted this most extraordinary testimonial to be printed in red letters on handbills and distributed in all the towns and cities of the North and East for the benefit of the benighted multitudes.

I do not propose to go deeply into the mathematics of refraction or the physiology or mechanism of accommodation, but if, by enumerating a few of the most common errors and reiterating some of the established facts in regard to the diagnosis

and treatment of refraction anomalies, I can aid in calling attention to this important branch of medicine. I shall feel that no apology is necessary for this platitudinous effort. To name the various groundless opinions and errors as held either by the profession or the laity would be an endless task. To classify them is also difficult. The most common errors, so far as my observation goes, are: First, errors in regard to the cause, character, and duration of anomalies of refraction; second, errors in regard to the diagnosis and correction of anomalies; third, errors in regard to the material of which lenses are made. An anomaly of refraction may be defined as an improper length of the visual axis, a disproportion in the distance between the dioptric or refracting power of the eye and the retina or receiving portion. This disproportion may be relative or absolute. In speaking of the refraction of an eye, reference is always made to the static refraction, unless otherwise stated; that is, to its power of converging parallel rays of light with its accommodation suspended—in hypermetropia, then, shortening of the visual axis so that parallel rays are brought to a focus behind the retina. It is not a pathological condition, but an anatomical defect. It is congenital, and, as a rule, permanent and unalterable. We can add to the refractive power of the hypermetropic eye by placing a convex lens in front of it, thus bringing parallel rays to a focus on the retina. This is done to correct the error, and not with the hope of curing it. Hypermetropia has very improperly been called "far-sightedness." The hypermetrope does not see perfectly at any distance. Hypermetropia of low and medium degrees is usually entirely masked by the power of accommodation in early life. In high degrees it is manifest even in youth. In this case we usually find the patient holding his book or work very near the eye in order to get a larger image even at the expense of distinctness. In high degrees of hypermetropia there is most always an arrest of development in the nerve structure as well as in the globe itself. Hypermetro-

pia of medium and low degrees becomes manifest sooner or later according to the occupation and general condition of the patient. The power of accommodation gradually lessens after the tenth year, by the forty-fifth year even low degrees of hypermetropia become manifest. Many think that by postponing the use of glasses they may "fight off" the trouble, and so strengthen the eye as to avoid their use altogether. Much injury is done in this way. As soon as failing accommodation makes near vision difficult or painful, it should be aided by the proper glass. The argument so often used, that when they once begin to use glasses they will never be able to discard them, is true, but illogical. If they never put them on, they always need them. In those cases of hypermetropia where there is increase of the refraction, the decrease in the hypermetropia is gained at the expense of the integrity of the globe. The elongation of the visual axis is due to a posterior staphyloma. When once the staphylomatous condition has begun, it rarely stops at emmetropia, but continues till we have a myopia with all its attendant evils. So the last state of the patient is infinitely worse than the first. It is a common belief that myopia, or near-sightedness, is a harmless error of refraction, if not indeed a desirable one. Myopia is due to an elongation of the visual axis, and not to increase of the convexity of the refracting system of the eye.

This elongation is never congenital, but always acquired. In short, myopia is due to pathological causes—an ectosis of the posterior wall of the globe. It is not a curable condition. The elongation generally increases from the period of invasion till about the eighteenth year, when the refraction either becomes stationary or it increases slowly. The reported cases of diminution of the refraction in the myopic eye are not well authenticated. Myopia is preeminently a disease of childhood and early youth. From the eighth to the fifteenth year marks the period of development in the vast majority of cases. The limit of this paper will not permit a discussion of the clinical his-

tory of the ectosia on which the myopia depends, but briefly I will say that I believe the so-called predisposition to myopia is much overrated; that the prime factor in the etiology of myopia is placing the labor and requirements of maturity on immature organs. By overtaxing the powers of convergence and accommodation, there is developed a choroiditis of the fundus. This in turn produces softening of the corresponding portion of the sclera, together with increased intra-ocular tension—the only factors necessary in production of posterior staphyloma. By the laws and customs of this country children enter school at the age of six years. Now, at a time of life when all the other functions and organs are in their infantile state, the eyes are required to take up the burden of an education, encumbered as they frequently are with uncorrected errors of refraction. Harassed and fatigued by poor light, ill-constructed desks, bad prints, and all the other unhygienic conditions of the average school-room, this baby eye is not only expected but compelled to do adult work.

Many myopics console themselves with the idea that when they are old they will be able to see perfectly without glasses. It is true the myopic eye loses its refractive power by age, just the same as the emmetropic or hypermetropic eye, but the elongation of the visual axis has generally increased sufficiently to counteract any diminution of refraction. Patients with low degrees are sometimes relieved by age. Those of medium and high degrees are not benefited. The reflex symptoms, such as headache, vertigo, and nausea, bear no constant relation to the degree of the error of refraction, but depend largely on the temperament and condition of the patient, low degrees of error often producing the most troublesome reflexes; this is especially true of astigmatic anomalies.

Now as to the second classification: The most common, and at the same time serious error in regard to the diagnosis and correction of refractive anomalies is the failure to distinguish between refraction and

accommodation, or, more properly, the failure to recognize the difference between static and dynamic refraction. Static refraction is something stable and constant, regardless of the physical condition of the patient; while the dynamic or accommodative refraction is variable at best, and in overworked and irritable eyes is positively fickle, so much so that a lens which gives perfect comfort during an examination will after an hour's work be insufficient to correct the error, or by a spasm of the accommodation the hypermetropic eye will not only reject a positive lens, but actually accept a negative one with apparent benefit. It is not uncommon to find hypermetropes who have made their own selection, or been fitted by some self-styled optician, wearing minus lenses. All attempts to accurately measure the refraction of a patient under forty-five years of age without first suspending his power of accommodation is always unreliable.

The diagnosis of anomalies of refraction with the ophthalmoscope, while it has many advantages, is not sufficiently accurate to be depended upon in the correction of errors of refraction. After having accurately determined the degree of error, the question is, how much of it must be corrected by glasses, and what portions must be left to the accommodation? This will depend largely on the age and condition of the patient. I think, as a rule, too much is left for the accommodation by prescribing too weak a glass, thus subjecting the patient to the trouble and expense of making frequent changes of his glasses. It is the common belief that when a patient needs glasses, or fancies he needs them, all that is necessary is to go to the jeweler or optician and try on one pair after another, just as they would a pair of shoes or gloves. Of course it is impossible to even approximate the condition of refraction in this way, for reasons already named. Besides this, each eye must be measured separately. The cases in which the refraction of the two eyes is different are much more frequent than is generally supposed, but is a condition out of which

the patient gets an immense amount of consolation, for some unexplained reason. I don't think I ever told a patient his eyes were not alike, but he went away feeling that he had the start of mankind in one particular at least. The patient's statement that he sees as much as any body, or as well as he ever did, is not to be relied on, as he has no way of comparing his vision with that of other people or with his own vision in former years. Frequently we find patients who insist that they see as well as any body, but when put to the test they fall short of perfect vision. Now, if the foregoing propositions are true, that the nature, cause, diagnosis, and treatment of refractive anomalies are so frequently misunderstood, then it is not surprising that there should be a general misapprehension in regard to the material out of which the correcting lenses should be made. Nor is it strange that the ametropes should hope by the subtle influence of some mysterious pebble to sharpen his vision, or that the presbyope should long for some magic crystal to restore the sight of his youth—just as the hopeless invalid yearns for some panacea or the decrepit old man sighs for a rejuvenator. They alike hope without reason, and alike fall victims to charlatans who prey upon their credulity.

Spectacle lenses are made of rock crystal, crown flint, and common glass. Those made from rock crystal are sold as pebble quartz and various other names, according to the taste of the vender. The essentials for lens material are transparency and refrangibility, with a minimum of dispersive powers. Opticians have found crown glass to come nearer these indications than any other material. Crown glass is the material used in the construction of microscopes and other scientific optical instruments, as well as that prescribed for spectacle lenses by every regular ophthalmic surgeon in practice. The much-vaunted rock crystal possesses absolutely no advantage over crown glass except its hardness, while it has the disadvantage of a high degree of dispersive power, so much so that a strong lens, instead

of bringing a ray of white light to a distinct focus, converts it into a veritable spectrum, with all the colors of the rainbow. Quite as much depends on the grinding of a lens as on its material. No matter what kind of a lens it may be, if it is not accurately and symmetrically ground it is worse than worthless. This is one of the troubles in the cheap glasses as sold by shopkeepers and jewelers.

LOUISVILLE.

## Societies.

### LOUISVILLE SURGICAL SOCIETY.

Stated Meeting October 14, 1889, Vice-President J. M. Mathews, M. D., in the chair.

The essay of the evening was read by Dr. W. Cheatham; subject, Tumors of Pharynx, with a report of two cases. (See page 353.)

#### DISCUSSION.

Dr. Ap M. Vance saw the first case with Dr. Dabney, who tried to snare it. The tumor, however, proved too tough, and was ill-shaped for successful removal by this also means. The patient went to the country, but came back in a few weeks with a greatly increased growth.

Dr. S. G. Dabney: It was something like two months after he first consulted a physician before I saw the case. With the rhinoscope he diagnosed fibroma and gave an unfavorable prognosis. He said if it was removed it would return. The patient saw Dr. Ray afterward, who also said the tumor was fibroma. Dr. Dabney believed it would develop into a sarcoma. He gave chloroform, and succeeded in getting off quite a piece. In ten days he tried again without success. It was clear that it could not be snared. He does not think the microscopic examination would have made any difference in his prognosis. He feared that operative interference would increase the rapidity of the growth. The doctor was absent from the city for a few weeks; when he came home he found much increase in the growth.

Dr. J. M. Ray saw the case in July. He

found a nodular growth in the naso-pharynx obstructing the right nostril. It was as large as a hickory-nut. He thought it had a narrow attachment. Considering the youth of the boy, he diagnosed fibroma, and favored removal by the snare with application of caustic to the pedicle. After finding that a less favorable opinion had been given by the other surgeons, he looked up the authorities on the subject.

Wagner says at 8-13 years fibroma occurs, and believes recurrences due to imperfect removal and cauterizing. Mackenzie says the same. This is the third case the speaker had seen; one was in the Manhattan Eye and Ear Hospital. He did not see it operated upon. The growth was very hard. It was removed by Dr. Gunter with a galvano-cautery, the pedicle being cauterized. There was no evidence of recurrence when he left the hospital. The second was a bleeding case. It occurred in the practice of Dr. Coomes. The tumor grew rapidly, filling the nose, pharynx, and orbit. Death was the final result. He saw Dr. Cheatham's case two years ago. The patient then complained of cold in the head. He examined it superficially. Patient was then a mouth-breather. Dr. Ray ordered an alkaline wash. His opinion of fibroma was based upon the firmness of the growth with absence of hemorrhage. Authorities claim that this growth occurs in males usually at ages between thirteen and twenty-five; this boy was twelve. He believed that removal and cauterization of the pedicle would probably cure the case. Lincoln reports a number of cases. Eleven tumors removed by galvano-cautery did not recur. Lincoln says soft fibromas have a marked tendency to undergo sarcomatous degeneration. He reports not only fibroma and fibro-sarcoma, but pure sarcomatous growths, which, when removed with cauterization of the pedicle, did not recur. He believes that in most cases recurrence may be thus prevented.

Dr. A. M. Cartledge said that the case taught a most valuable lesson, especially as to the operation. The fact that such growths are near the bone, and have a marked tend-

ency to recur as sarcoma, indicates the necessity of very thorough removal. He thinks, when an array of cases are reported as removed by galvano-cautery without recurrence, they were not sufficiently watched for a long time. He favors the removal of the superior maxilla in large growths. He was struck with the frequency with which fibromatous growths recur as sarcomas. He had recently a case of nail-splitting by a fibroma of the big toe, the growth coming up through the nail. When he saw the case his opinion was unfavorable. He split and removed the growth; found it to come from the phalanx. Without any thing to excite growth, in three weeks it had returned and grown three times its original size. He amputated the toe in June. There has since been no recurrence. If it again returns he will cut off the foot. Examination showed a typical sarcoma.

Dr. W. O. Roberts believes with Dr. Cartledge that unless the removal be thorough operative measures but aggravate the case. In a case like the one under discussion he would split the palate or remove or split the jaw. He doubts the efficacy of the galvano-cautery. Annandale last fall split open the palate, removed a tumor from the nasal cavity in a case like this, and then returned the parts to their places.

Dr. Vance believes that the surgeon should split the soft palate and try to remove the growth with angular scissors, splitting perhaps the wing of nose. By these means he might get all the growth. This should be tried before attempting the big operation.

Dr. Cheatham, by electrolysis with a double needle, has destroyed some growths of this kind. Wagner tore one of these tumors out with a forceps, and although it was shown to be a fibro-sarcoma there was no recurrence in four years.

Dr. Roberts reported a case of traumatic aneurism. On the 5th of May last a man, twenty-eight years old, received a gunshot in the right thigh. The wound healed in three weeks, but near wound\* of exit on the inner side of the thigh a pulsation appeared. Aneurism was the diagnosis. September 25th,

having been up and about, he was advised to stop work by his physician, who brought him to me. Examination revealed the following:

Superficial veins somewhat enlarged. By sight, feeling, and hearing, the signs of aneurism were evident. Palpation showed a small tumor of the femoral in upper part of Hunter's canal—diagnosed aneurismal varix. He advised an operation, which was done September 27th. Esmarched the limb up to the groin. A large incision was made in the course of the femoral artery, the wound of exit being the center of the incision. In the fascia lata a tumor the size of the thumb was found and incised. Notwithstanding the Esmarch there was some oozing of blood. He found a tumor of the artery and vein. Ligatures were put around both vessels, going an inch and a half above and below the tumor. They were tied tightly. He loosened the Esmarch, when bleeding came on and continued from the mouth of the sac from two feeders. He ligated these, but there was still oozing. He then put a second ligature around all the vessels with success. Horse-hair drainage was secured. The leg was quite cold on removal of the Esmarch. The limb was dressed with bichloride gauze and absorbent wool with a flannel bandage. Patient was sent to the infirmary. The operation was done at 11 A.M. at the college clinic. Early in the afternoon the foot was still cold. Hot bottles had been used with no apparent effect. Sensation was not affected. Ten hours after the operation the foot was warm. On the third day the temperature was 101°. There was some pus at the lower angle of the wound. He thinks the horse-hair used for drainage at this point was not properly prepared. The patient did well and went home, cured, October 3d. Did the ball penetrate the vessels or did it only bruise them?

#### DISCUSSION.

Dr. Cartledge: Did you cut between the ligatures?

Dr. Roberts: The ball did not sever either vessel. I did not cut between the ligatures.

Dr. Cartledge thinks the outer tunic was wounded, being probably struck by the ball, which rebounded. A ball may strike a vessel

and damage the inner tunic without breaking the outer one.

Dr. Vance thinks the vessel was not opened. He would like to know if the Esmarch had any thing to do with the coldness of the leg.

Dr. Roberts: The operation was done very quickly. I don't think the Esmarch had any thing to do with making the leg cold.

Dr. Roberts further reported: A butcher, seventy years old, had hernia. He had worn a truss that was ineffective. The gut came down. Dr. Larrabee by much effort reduced the hernia. Last Friday I saw the patient, who then had strangulation. The tumor was the size of a duck-egg. There was also hydrocele. At 10:30 I gave chloroform, but failed to reduce it. I urged an operation, but this was refused. In the afternoon there was vomiting and hiccough. The man was still obturate. On Sunday he was unchanged. I told him that unless he consented to the operation I would quit the case. At 1 o'clock P.M. he sent for me, and at 3 I operated. I separated the sac before opening it. When cut it discharged 3½ss of reddish serum. There was no omentum in the sac. The gut was very dark, with clots on surface. I divided the stricture; twisted, turned, and closed the sac; tapped the hydrocele, and got a quart of fluid. I closed all the wounds except the lower angle. No drainage. The ordinary dressing was used. He got an enema on the third day. He got also occasional doses of morphia. He had no trouble until the fifth day, when he became insane. I think the mania due to the morphia. It is now gone. From the start the patient would get up to urinate. Marcey closes the wound and paints it with iodoform and collodion, using no other dressing.

Dr. Vance said he was glad to hear that Marcey is using iodized collodion. He has in experimental operations on dogs been using it with fine results. The doctor reported the following case.

A young man suffered compound dislocation of the right wrist. Wound back of annular ligament. The bones had been driven into ground, a fill of scrapings. On examination it was found that four flexor tendons had been torn loose. The wound was cleansed and the disloca-

tion reduced. The hand had been cold, it now became warm. In eight hours temperature arose to 103°—malaria? Arm next day much swollen, hand least of all, circulation good. Dusky redness appeared on upper arm in twenty-four hours with a slight blister. Prognosed gangrene, thirty-six hours circulation good; forty hours little finger blackened, and dusky brown above middle of arm. 'I amputated through infiltrated tissue one and one half inch below shoulder-joint. The skin was dusky on the chest. Milked the flaps. In an hour temperature fell to 98.6°. Every thing went well. Forty-eight hours after tetanus appeared; forty-eight hours later he died with the wound healed. Although the tissues were filled with gangrenous juices, yet they healed nicely. He was treated with bromide, twenty-four drams in twenty-four hours, and then five drams in ten hours; whisky and morphia also were given.

E. R. PALMER, M.D.,  
*Secretary.*

#### THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

The second annual meeting of this Association was held in Nashville, Tenn., November 12, 13, and 14, 1889.

The Association was called to order by the president, Hunter McGuire, of Richmond, Va.

Dr. R. B. Maury, of Memphis, contributed a paper entitled Report of Gynecological Work, with Especial Reference to Methods. The paper presents a brief summary of the more important portion of his operative work during the past year. With four exceptions all of the operations reported were done in a private hospital, built especially for the purpose and under his own control. The summary embraces twenty-one laparotomies for the removal of ovarian tumors or of the uterine appendages, or for the relief of obscure disease within the abdomen; two laparotomies for ectopic gestation; twenty-eight operations for laceration of the cervix; fourteen perineal and vaginal prolapse operations; five rectoplasties; four anterior colporrhaphies.

Dr. Maury summarized the methods as follows:

1. An aseptic field of operation, and an aseptic surgeon.
2. A small incision in case of inflammatory disease in the pelvis, just large enough to introduce and work with two fingers.
3. Aseptic silk ligatures, as fine as may be consistent with safety in tying.
4. Enucleation of diseased structures in spite of firm adhesions and even profuse hemorrhage.
5. Irrigation by means of the siphon-trocar as a substitute in most cases for sponging, using simple hot water for this purpose and excluding all antiseptics.
6. Drainage often, and whenever one is in doubt as to its necessity.
7. Careful replacement by spreading out of the omentum before proceeding to close the wound.
8. Inclusion of all the structures in passing the abdominal wall sutures, and replacing the deep sutures one half an inch apart.
9. The use of means for moving the bowels on the second or third day after removing the appendages, and the avoidance, if possible, of opium.

Dr. W. O. Roberts, of Louisville, Ky., read a paper on Direct Herniotomy, in which he reported ten cases, with eleven operations. Seven cases occurred in females, three in males. Three were cases of umbilical hernia, three were femoral, three inguinal, and one ventral. Six of the operations were done during strangulation, while five were performed for troublesome irreducible hernias. In the six cases of strangulated hernia the sexes were equally represented. Three were inguinal, two femoral, and one umbilical. In five of them the operation for radical cure was done. The remaining case was one of strangulated hernia, where stercoraceous vomiting existed for eight hours before it was seen. General peritonitis was evident at the time of the operation. Much reddish stuff escaped when the contents of the sac were returned. Death followed in thirty-six hours. He had since

thought that if after returning the contents of the sac he had done a low median laparotomy and washed out the peritoneal cavity the result might have been different.

The four cases of irreducible hernia were all in females. Two were umbilical, one femoral, and one ventral. In one of the former a second operation was made necessary by the hernia recurring at the end of six months. The tumor also reformed at the end of ninety days in the case of femoral hernia. The remaining eight cases continue well to the present date.

In all the cases the sac was first cleanly dissected out and not opened until all hemorrhage was completely checked. Both in the ventral and umbilical hernias the integument and fascia were divided by an elliptical incision. After opening the sac all adherent omentum was tied with catgut and excised. The remaining contents were then returned into the cavity. In one case of umbilical hernia the neck of the sac was tied close to the margins of the opening, and cut away immediately in front of the ligature. The stump was then fastened tightly in the opening with silk-worm gut sutures, and the wound finally closed by interrupted sutures of the same material. In this case no supuration occurred, but the hernia recurred at the end of six months. In both the other umbilical and in the ventral hernias the neck of the sac was excised on a level with the abdominal opening and sutured with catgut. The opening itself, after its edges were freshened, was closed with the continued suture of chromatinized catgut in the ventral hernia, and aseptic corded silk in the umbilical cases. The surfaces were brought together by silk sutures, which were continued down to the aponeurosis.

In the femoral hernias he adopted the practice of Mitchell Banks. In the cases of direct inguinal hernia, after tying the neck of the sac just within the ring, and removing all in front of the ligature, the ring was closed with catgut sutures.

In the cases of oblique inguinal hernia he did Mr. Ball's operation, which consists in freeing the neck of the sac up to the inter-

nal opening, ligating it, cutting away all in front of the ligature, then twisting the neck upon itself to effect closure of the peritoneal orifice, and finally stitching the stump to the pillars of the ring to guard the neck against untwisting itself.

A paper on the Abortive Treatment of Acute Pelvic Inflammation was read by Dr. Virgil O. Hardon, of Atlanta, Ga.

He said the views held by gynecologists in regard to acute inflammation in the female pelvis have within the past few years undergone a radical change. The inflammatory processes formerly regarded as idiopathic, or at least primary affections, are now almost universally recognized as dependent upon antecedent disease in the ovaries or fallopian tubes, especially the latter. This change of opinion has to a large extent been due to the result of advances in surgery which have enabled the conditions of the pelvic organs to be studied in the living subject by immediate inspection and palpation instead of through the medium of the vaginal tissues, consequently it is seen that a change of opinion on this subject has been most marked among those men who have had large experience in abdominal work. The diagnostic value of abdominal section under such circumstances is almost as great as that of *post-mortem* examination, and hence the opinion of the laparotomist is entitled to very great weight. As a result of this mode of observation the conclusion can not be avoided that acute pelvic inflammation is, at least in the majority of cases, associated with septic, gonorrheal, tubercular, or some other form of inflammation of the tubes. There are two forms of inflammation which are recognized as occurring within the pelvis as a result of tubal disease, pelvic cellulitis and pelvic peritonitis. In many cases both forms of inflammation are simultaneously present in the same subject, and it is not improbable that in all cases when either is present the other also exists in a greater or less degree.

It is hardly possible, when one considers the anatomical relations of the pelvic cellular tissue to the peritoneum, to conceive

of an inflammation of the one structure without a greater or less implication of the other. In the majority of cases one form of inflammation can be recognized as forming the preponderating element of the disease, to which the other plays only a secondary rôle.

The constitutional symptoms consist of acceleration of the pulse, elevation of temperature, severe pain in the pelvis extending down the thighs, tenderness of the hypogastric region and inguinal region, a sense of weight and fullness in the pelvis, difficult micturition, and painful defecation. These symptoms are most marked in the acute stages, and are somewhat diminished as soon as solidification has taken place. They continue, however, with lessened intensity into the third stage of the disease.

The treatment consists in the withdrawal of the effusions from the cellular tissues by means of the aspirator, etc. Where pus-tubes are present he would advocate their removal.

Dr. Joseph Price, of Philadelphia, said his experience was a little different from that of the essayist. Relief from salines and the aspirator in the cases reported may have been justifiable, but pus-tubes in every instance call for abdominal section. He then exhibited some pus-tubes, one of which was seven inches in length, and called attention to their frequency in cases of pelvic inflammation. He said, thirteen years ago a woman living in Pottsville was treated by a prominent gynecologist for pelvic peritonitis. Sponge tents were used, and the patient made a doubtful recovery. Eight years ago Dr. Goodell effected drainage through several sinuses then existing, three or four being about the sacral region, two or three in the groins, and one in the anterior abdominal wall. Six weeks ago Dr. Price evacuated two gallons of pus in the same patient. A perfect recovery was brought about in some of his cases only by abdominal section and the removal of pus-tubes. The history and symptoms in his cases were identically those mentioned by Dr. Hardon. In the light of our present accurate knowl-

edge, acquired by a large experience in the pelvis, the conclusion is that the entire subject of pelvic peritonitis and cellulitis will have to be rewritten. The sharp distinctions between the one and the other are refinements that the surgeon no longer seeks. Peritonitis, the result of tubal and ovarian disease, is exceedingly common. Gonorrhea is the most common cause of all.

Dr. George J. Engelmann, of St. Louis, said there was a fascination in the results achieved by Dr. Price and other operators, but he thought the pendulum was swinging too far in that direction. He could indorse the surgical treatment advocated by Dr. Price in dealing with cases of pelvic inflammation which result from salpingitis, or where there was pus in the tubes. Many of the cases which were formerly called pelvic cellulitis are the sequences of salpingitis, or pus in the tubes, and he was satisfied there are cases which exist without salpingitis.

Dr. W. G. Ewing, of Nashville, said that when he began to practice he was on the conservative side, but is satisfied that many of the cases which came under his observation could have been dealt with surgically and successfully. He favored early operative interference, and said the surgeon should not delay in such cases, for by so doing additional adhesions were apt to form with extension of the inflammatory process.

Dr. Hardon, in closing the discussion, said he feared he had been misunderstood, but would now say that pus-tubes admitted of but one rational treatment, and that was their removal. He invariably recommends this to be done. But what should the surgeon do with those patients who will not permit an operation?

As regards pelvic cellulitis, without disease of the tubes, he could corroborate the statements of Dr. Engelmann, and called attention to two cases he reported last year to the Association which verified the fact. In these cases he aspirated, and withdrew several drams of serum from the cellular tissue. Subsequent examination revealed absolutely no disease of the tubes. He has examined these patients from time to time, but not the

slightest evidence of tubal disease could be found, and there has been no recurrence of the pelvic inflammation.

Dr. W. D. Haggard, of Nashville, read a paper on the Improved Cesarean Section *versus* Craniotomy, in which he said that the improved cesarean section offers justifiable means of saving both mother and child, and relieves the heart and conscience from the charge of scientific murder. Embryotomy on a living child will soon cease to be regarded as scientific, or even a justifiable operation. This seems to be foreshadowed by the statistics of Caruso, who reports a case in detail by Sanger, and one by Zweifel, and adds statistics up to October 1888, comprising 135 cases. Six successful cases were known in addition to Caruso, but the details necessary for publication were lacking. German operators have performed 74 of these operations; Americans, 18; Austrians 16; the results obtained by American surgeons being inferior to those of German and Austrian operators. The results show a large per cent of recoveries among mothers in all cases, and a still larger per cent in the case of children. In three cases in which the operation was done a second time, both mothers and children recovered. A careful estimate of the results of craniotomy, under antiseptic precautions, shows that 23.04 per cent of mothers recover. Selecting similar cases on which section was performed, the percentage of recoveries in these cases was 89.04, and 100 per cent of children.

Dr. W. H. Wathen, of Louisville, read a paper entitled The Treatment of Ectopic Pregnancy.

This paper was followed by important remarks on perineorrhaphy, by Dr. A. W. Johnstone, of Danville, Ky.

Dr. Joseph Price, of Philadelphia, contributed a paper on Pus in the Pelvis, and How to Deal With It. By pus in the pelvis, he meant pus that has its *fons et origo* in the pelvic organs or their investment. The rarer causes of pus in the pelvis may be said to be: (1) Carious bone, as psoas abscess; (2) traumatism, sloughing, results of electricity, direct violence, etc.; (3) foreign

bodies, as extra uterine bones, etc. The general rule is, that pus in the pelvis is always the result of diseased conditions of the uterine appendages, whether it occurs as a result of a ruptured extra uterine pregnancy, a suppurating ovarian or dermoid cyst, or salpingitis caused by gonorrhea, parturition, dirty instruments, electricity, or what not. In general, then, when the surgeon finds pus in the pelvis he will find its origin in the uterine appendages. He had seen pus discharging from the rectum, from the bladder, the umbilicus, and from the vagina. He had seen psoas abscess, perforating appendicitis, idiopathic peritonitis, and perityphlitis, and found the seat of trouble in the tubes and ovaries. In all his experience he had never seen pus in the pelvis independent of disease of the appendages. To make the statement definite, he had seen more than once trouble pyosalpinx and double ovarian abscess contained in a pus-pocket in the peritoneal cavity, composed of adherent intestines and inflammatory tissue, four abscess cavities contained within a fifth. Again, he had seen a single pus-tube with four distinct pockets in it. Pus can burrow through the cellular tissue and find vent as before stated. How shall pus in the pelvis be treated? The general principles of surgery for the treatment of pus in any other part of the body apply with equal force to the pelvis, namely, where pus is present, evacuate it and secondly, remove the cause of the suppurative process. It is equally unsurgical and unscientific to allow it to remain in the pelvis as it would be to allow it to remain in the brain, in the mammary gland, or under the fascia in any part of the body. It is equally unsurgical to allow a suppurating tube or ovary to remain in the pelvis as it would be to allow a sequestrum of dead bone, or to allow a necrotic placenta or membranes to remain in the uterus. These principles do not admit of evasion. All sorts and kinds of treatment have been tried without avail. Every man of experience knows the futility of counter-irritation, local depletions, or a general systemic treatment in the majority of cases.

There are only three methods of treatment common to physicians to-day, namely, electricity, vaginal drainage, and abdominal section, with the removal of the diseased parts, thorough irrigation of the peritoneal cavity, and drainage.

The first of these methods need scarcely be mentioned in cases where pus is already present. Electricity has no place in the treatment of pus in the pelvis. Vaginal drainage is a crude, inefficient method, and is not as safe as some would have us believe. In abdominal section we have the quickest, easiest, most exact, and therefore safest mode of treatment for pus in the pelvis. A small incision, rapid enucleation of the offending tubes and ovaries, the breaking up and evacuating of the separate pus-pockets, the separation of adhesions, the thorough washing out of the peritoneal cavity by copious irrigations of warm distilled water, the placing of a glass drainage-tube in the most depending portion of the peritoneal cavity, and the careful closure of the abdominal incision, give the patient the quickest relief, permanent cure, and very often snatch her from an impending death. Moreover, here we attain the most ideal treatment, for at no other point of the body can we enucleate completely an abscess with its containing walls and pyogenic membrane. However, we should always bear in mind that the province of the surgeon is, first, to save life, then to relieve suffering, rather than to perform ideal operations. Many patients dying with pus in the pelvis need but a feather's weight to depress the beam. In such cases the indications are to evacuate the pus, wash out the cavity, and wait until a future time to remove the offending cause.

Dr. W. L. Robinson, of Danville, Va., read a paper on Gynecology in its Relation to Obstetrics, in which he spoke of the cervix uteri in its pathological condition predisposing to hemorrhage prior to labor, laceration, and septic absorption. He could find no explanation in medical literature of the cause of ulceration of the cervix, non-specific and non-malignant, causing hemorrhage in

two cases which came under his observation within the last twelve months. He used the word "non-specific" because of the perfect health of patients prior to the pregnancy and since delivery—his knowledge and intimate acquaintance for years with husband and wife. The first case was seven months advanced, the patient spending summer in the mountains for the benefit of one of her children. She found herself unwell after a week, and the flow was sufficient to soil the clothing and require napkins. A physician was called who gave ergot and opium, which controlled it in twenty-four hours. Two weeks subsequently the conditions repeated themselves, and relief was obtained by the same remedies. She returned to the city and was again annoyed by a like hemorrhage, which came on about 7 P. M. daily, in spite of the efforts of the attending physician to control it, which continued until the sixth day, the patient having reached home. Dr. Robinson was called, and made an examination with speculum. He found the os granular, denuded of its mucous coat, and upon gently opening the os with uterine dilators he discovered a small clot adherent to the ulcer, which caused bleeding when removed. He applied carbolic acid to ulcer, and dusted the os and vagina with boric acid. He continued treatment until the parts were in a healthy condition, and delivered the woman at full term without hemorrhage, tear, or any unusual sequelæ. No placenta previa existed, and not one drop of blood escaped after the first application of carbolic acid until after delivery, and then every thing was normal. The second case occurred a few weeks subsequent to the first, with history and result similar.

He has for several years made it a practice to examine his regular patients whenever a yellowish or dirty white vaginal discharge exists, especially if the vulva is in a state of irritation, and almost invariably finds the os granulated, whether lacerated or not, and he persistently treats them until restored to a healthy condition, explaining to the patient the importance of such treatment.

Dr. Bedford Brown, of Alexandria, Va., corroborated the statements of Dr. Robinson by the citation of a case. The patient had a bilateral laceration of the cervix. She became bitterly hostile to sexual intercourse with her husband, and had an intense dislike of his company and presence. This preyed upon her mind to such an extent that she became insane. He treated the case with applications of nitrate of silver, and the lacerations healed perfectly. After this all symptoms entirely disappeared. The patient regained her reason, her affection for her husband, and had lost the hostility to sexual intercourse which she had. She has since borne three children. Dr. Brown has examined the condition of the cervix after each birth, and the repair is perfect.

Dr. Hunter McGuire delivered the Presidential Address, which was scholarly, timely, and well received.

Dr. George J. Engelmann, of St. Louis, read a paper entitled Menstruation and Pregnancy after Removal of Both Ovaries.

The following are the conclusions drawn from the history and microscopical examination of Dr. Engelmann's cases, which are corroborated by numerous cases of oöphorectomy and double ovariectomy now observed, whose histories have been recorded for a sufficient length of time after the operation:

1. That the continuance of menstruation after the removal of both ovaries is due to remnants of ovarian stroma left *in situ*.

2. That portions of the ovarian tissues, however small, which remain after the removal of the greater portion of the organ, whether or not the fallopian tube be preserved, may retain their activity and continue the functions of the entire organ.

3. Even elongated pedicles may contain ovarian stroma in which the functional activity of the organ may be continued.

4. That remnants of ovarian stroma do not necessarily preserve their vitality and functional activity.

The deductions of practical value to the operator are even of greater importance, and they are these:

- (a). For the successful performance of oöphorectomy it is requisite that every particle of ovarian stroma shall be removed if the desired result is to be expected with certainty.

- (b). If shrinkage of fibers, the limitation of hemorrhage or cessation of annoying symptoms is to be accomplished with the greatest certainty, both ovaries must be completely removed, and not even a particle of ovarian tissue left *in situ*.

- (c). In the performance of double oöphorectomy in women not yet beyond the climacteric, and not suffering from utero-ovarian reflexes, such healthy ovarian tissue as may exist should be spared in order that functional activity may not be impaired.

Dr. W. D. Haggard, of Nashville, said it is very rare for a woman to menstruate regularly after removal of both ovaries and both tubes. He believed that the hemorrhagic discharges from the uterus after oöphorectomy depended upon some other cause than that of menstruation. It may depend upon some trouble connected with the endometrium, as suggested by Dr. Engelmann, a polypoid growth, or a congested condition of the blood-vessels which supply the endometrium. In January last he removed both ovaries and both tubes in a woman, and it is barely possible but of ovarian stroma were left behind, as three months later the patient continued to have hemorrhagic discharges which greatly annoyed her.

Dr. A. W. Johnstone, of Danville, Ky., held that the ovary has no more to do with menstruation than the clitoris has. To prove this he had left ovarian tissue behind, yet menstruation had ceased. Dr. Johnstone gave at length his reason for this theory.

Dr. Virgil O. Hardon, of Atlanta, Ga., had operated on a patient about eighteen months since for a bleeding fibroid tumor, removing both ovaries; and in removing the second ovary he feared he had not removed all the ovarian tissue, as the precarious condition of the patient would not permit a continuance of the operation. The

patient recovered from the operation, and has menstruated with unvarying regularity from that time to the present.

Dr. Richard Douglas, of Nashville, said that Battey's operation of itself does not control menstruation, whereas in Professor Tait's operation, which consisted in the removal of both ovaries and both tubes, the gynecologist embraces in his ligature the nerve which controls menstruation.

Dr. A. V. L. Brockaw, of St. Louis, warmly took exception to the remarks of Dr. Johnstone, who was inclined to give Tait the credit of first performing oöphorectomy. He said he admired Tait's skill as an operator, but as a man he did not, for with characteristic modesty he (Tait) adds his name to operations that do not rightfully belong to him; as, for instance, the flap-splitting operation.

Dr. A. W. Johnstone: The statement made by Dr. Brockaw, that Tait claims to be the originator of the flap-splitting operation, is not true. A full description of the method could be found in a recent issue of *Mundé's Journal*. It is true, however, that Tait had used it without knowing it had been described some twenty years ago by a Dublin surgeon, but he has given him due credit for the operation.

Dr. John D. S. Davis, of Birmingham, Alabama, then read a paper on an Experimental Study of Intestinal Anastomosis, in which he reported thirty-two adhesive experiments on dogs and seventy-nine successful anastomotic operations by means of his approximation catgut mats and catgut plates, for the purpose of illustrating the advantages of denuding the coaptation serous surfaces, and the integrity and absorbability of his catgut mats and plates.

He reported two applications of anastomosis to man. The first, ileo-colostomy for obstruction in the region of the ileo-cecal valve, by means of catgut mats; the second, jejuno-jejunostomy for multiple gunshot injuries of the jejunum, with resection and lateral approximation by means of catgut plates.

His paper was replete with suggestive

advantages of anastomosis over circular enterorrhaphy, based on experimental facts. His anastomotic devices consist of catgut mats and catgut plates, oval and horse-shoe. The mats are made of catgut in the following manner: A large continuous four-rib catgut frame is held in an oblong shape by four artery forceps, while the frame is being interwoven into an oval mat of the desired size by means of a small catgut thread armed with a needle. The coaptation-threads are fixed by passing a needle and thread between the two middle ribs, and so returned as to loop two or three of the small gut sutures used in weaving the ribs together. The plates are made of any size, by means of an ordinary pocket-knife, from a large one eighth inch thick dry compressed plate of the uncut gut tissue, made for the author by William Snowden, Philadelphia. The coaptation-threads are fixed by passing them through the plates by means of a needle, or, better, by means of an awl, and knotted to fix them. The horse-shoe plates are made from the oval plates by cutting out one end of each of the oval plates. They are used for closing, in a hinge manner, extensive gunshot wounds of the convexity of the bowel.

His paper closed with the following propositions:

1. Approximation catgut mats may be made of any size in less than an hour.

2. Approximation catgut plates may be made of any size in from ten to fifteen minutes.

3. Approximation catgut horse-shoe plates are very valuable in intestinal repair from gunshot injuries of the convexity of the bowel.

4. Approximation catgut mats and plates absorb away in from forty-eight to sixty hours in gastro-enterostomy, and in from seventy to eighty hours in operations below the stomach.

5. Anastomosis by means of approximation catgut mats or plates furnishes the best conditions for the healing of the visceral wound.

6. Anastomosis can be performed by

means of catgut mats or plates without division of bowel in five minutes, and with division or resection in fifteen minutes, including a continuous outside safety silk suture round the circumference of the mats or plates.

7. Denuding the peritoneum of endothelium at the seat of coaptation hastens the exudation of plastic lymph, the formation of adhesions, and the definite healing of the intestinal wound.

8. When coaptation serous surfaces have been denuded of their endothelial covering by mechanical scraping, plastic adhesions readily take place, and definite healing, by the formation of a net-work of new blood-vessels in the product of tissue proliferation from the coaptation serous surfaces, is initiated in eighteen hours.

Dr. Davis' paper was followed by one entitled *Intestinal Anastomotic Operations with Segmented Rubber Rings*, with some Practical Suggestions as to their Use in Other Surgical Procedures, by A. V. L. Brockaw, of St. Louis, Mo.

For many months the author has been experimenting with segmented rubber rings in all the anastomotic operations, and such operations as gastrotomy, cholecystotomy, duodeno-cholecystotomy, jejuno-cholecystotomy, and circular enterorrhaphy. The rings used by him are rapidly made, during an operation if necessary. All that is required is some rubber tubing or a soft ordinary rubber catheter and some catgut. He prefers tubing one eighteenth to one eighth of an inch in diameter. A section of this of sufficient length to make a ring of the desired aperture is cut into four to eight segments. Passing heavy strands of catgut through the lumen of these pieces, the ends are tied tightly enough to bring the ends of all segments together, forming an oval-ring. To the catgut strands are tied from four to six apposition-threads twelve to fourteen inches long, and the attachment of needles to these threads renders the ring ready for use. Another method is to pass a heavy double strand of catgut continuously through the segments

several times, approximate the ends of the segments and push the ends of the catgut into the tubing. This ring will have a better surgical finish, and after the apposition-threads are tied between the segments the ring will maintain its perfect form until the catgut is absorbed. The rings were passed as early as the fifth day in one of his experiments. In forming an anastomosis, after ordinary No. 6 darning needles are attached to the apposition-threads, compress the ring and pass it through the opening made in the lumen of the bowel then pass the threads through the intestinal wall from within outward. Ascertaining that the ring rests well in place, proceed to the second in the same manner; appose, and after scarification of the marginal serous surfaces, as suggested by Senn, tie the apposition-threads. When possible, it is well to utilize omental grafts, which add to the security. With two such rings circular enterorrhaphy may be performed, the rings corresponding in size to the lumen of the bowel, care being taken that they are not so large as to press too much upon the delicate mucosa or to overstretch the bowel as a local gangrene might then follow. Introducing a ring at each end of the gut at the point of section, the threads are passed through the wall less than one third of an inch from the divided margins. The distal end of the gut is invaginated and the proximal gut pushed into the distal, bringing the serous surfaces in contact. The threads are then tied and a few Lembert sutures added, the entire operation requiring less than ten minutes. In one half of his experiments with this operation the result was excellent. Of the fourteen dogs operated on by this method, in seven the results were all that could be desired; marked stenosis was found in several cases, and in all a ridge at the seat of the operation.

In a recent paper the essayist mentioned a new procedure of closing large wounds of the intestine, especially gunshot, where by ordinary suturing stenosis would result. This method applies to wounds of the surface of the intestine; those of the mesen-

teric portion usually require resection. By this simple method wounds the size of a half dollar may be closed in less than five minutes. The wound being trimmed and enlarged with scissors, a ring two and a half inches in diameter, made of eight segments of tubing, with six apposition-threads, two on each side, is so arranged that when the apposition-threads are tied the ring is held bent evenly on itself. Such a ring is introduced into the bowel, the end apposition-threads passed, then the lateral, using a single catgut suture in drawing the wound margins together at the point of flexure in order to prevent eversion. A few Lembert sutures complete the operation. If two wounds are close together in the same loop, a lateral anastomosis might be formed if possible. With more than two wounds close together, excision and lateral anastomosis will require less time than circular enterorrhaphy or the sewing up of several wounds. Other conditions where the single ring may be used are perforating ulcers, fistulas, etc. The great advantage of the segmented rubber rings over other devices used is the simplicity of their construction and the rapidity with which any number may be made. The large aperture of segmented rings makes it possible to perform ileocolostomy by the following method, which the author believes is original: The ileum being divided a short distance from the cecum, the divided end of the distal bowel is invaginated into itself and secured by a continuous suture through the serous and muscular coats. Above the proximal end a clamp is placed and a ring adjusted to the lumen; a slit is then made in the convex surface of the ascending colon and a ring introduced. The bleeding checked, the proximal end of the divided ileum is inserted into this slit, the threads tied and Lembert sutures added. This operation may be quickly performed, and is indicated in such cases as irreducible intussusception of the ileum into the cecum and malignant diseases of the colon.

Appended is a series of operations, with the results:

Gastrostomy—2 experiments, 2 recoveries.

Gastro-jejunosotomy—3 cases, 2 recoveries, 1 death from peritonitis. (Dog tore one suture eight days after operation.)

Jejuno-ileostomy—1 case, result perfect.

Ileo-colostomy—2 cases, 1 death due to perforative peritonitis.

Ileo-colostomy—2 cases, 2 perfect results.

Colo-colostomy—3 cases, 1 death.

Ileo-rectostomy—2 cases, perfect results.

Circular enterorrhaphy—14 cases, 7 deaths.

Duodeno-cholecystotomy—3 cases, 2 deaths from peritonitis. (This operation is difficult to perform on a dog, for anatomical reasons).

Partial duodenectomy—2 cases, 1 perfect result.

Partial jejunectomy—2 cases, 2 perfect results.

Partial ileoectomy—4 cases, 1 death.

Partial colectomy—2 cases, perfect results.

*Summary:* Intestinal anastomotic operations, 14 cases, 3 deaths. Circular enterorrhaphy, 14 cases, 2 deaths.

The single ring formed of eight segments of tubing was used in closing wounds varying in size from a quarter to half a dollar in nine cases, with one death. The clamp devised by him and used in the operations is made of No. 12 copper wire covered with unperforated rubber tubing of small size.

[TO BE CONTINUED.]

## Reviews and Bibliography.

*Cyclopedia of the Diseases of Children*, Medical and Surgical. The articles written especially for the work by American, British, and Canadian authors. Edited by JOHN KEATING, M. D. Vol. II. Illustrated. Pages, 1066. Philadelphia: J. B. Lippincott Company. 1889.

In reviewing the first volume of this very excellent and comprehensive work, allusion was made to the fact that owing to the various chapters having been written by different authors there was to be found not a little overlapping. In the present volume that fault, almost unavoidable under the circumstances, is

also to be remarked, as is also the disposition to embrace every thing that can by the most strained propriety be brought under the head of diseases of children. One might reasonably suppose that where a disease is both common to children and adults, and requires identical treatment in both cases, it might be relegated to treatises on general practice. More especially is this the case in surgical diseases. There can hardly be more reason for considering dislocated jaw as a disease of childhood that does not justify the consideration of broken leg also. But when it comes to treating of gunshot wounds of the spleen, even in an encyclopedia of diseases of children, we think the point for the line to be drawn has been certainly reached.

Not all the illustrations, too, seem to have been taken from subjects properly embraced within the term children. Notably, the figure illustrating sarcoma of the antrum has been taken from a subject in middle life, or otherwise sarcoma must have a powerfully ageing influence.

Finding the scope of the work apparently takes in all debatable ground, we sought to discover if any omissions had been made. Only a single notable one has been found. Nothing is said about a not very rare instance of teratology known as pharyngeal, or, more properly, as branchial fistula. This is a curious affection and also puzzling in treatment. These fistulæ are caused by failure of the embryonic branchial slits to close, resulting in small fistulous tracts opening commonly both within the pharynx (sometimes within the larynx) and externally. Of the size of a small probe, they may open anywhere from the angle of the jaw to the middle of the sternum. They are harmless, but, not being generally understood, it often happens that apprehension of future danger leads to futile and annoying efforts at treatment. As far as we know, they are mentioned by but one authority in the English language, the *International Encyclopedia of Surgery*. They can hardly be rare, as in this city alone a single medical society has four undoubted cases under observation. Like failure of the closure of branchial slits higher up, cause similar fistulæ about the external ear.

Their consideration is certainly entitled to a place in an encyclopedia of diseases of children.

In spite, however, of the faults referred to, this is a most valuable publication, and no general practitioner can feel perfectly happy without being the owner of the *Encyclopedia of Diseases of Children*, after once it has passed under his inspection. D. T. S.

**Ophthalmology and Ophthalmoscopy:** for Practitioners and Students of Medicine. By Dr. HERMAN SCHMIDT-RIMPLER, Professor of Ophthalmology and Director of the Clinic in Marburg. Translated from the third German edition. Edited by D. B. ST. JOHN ROOSA, M. D., LL. D., Professor of Diseases of Eye and Ear in New York Post-Graduate Medical School; Surgeon to the Manhattan Eye and Ear Hospital. One hundred and eighty-three wood-cuts and three colored plates. Being Vol. I of *Specialties in the Practice of Medicine*. New York: William Wood & Co. 1889.

The thanks of that portion of the profession who are unfamiliar with the German language are due the firm of William Wood & Co. for the presentation of a translation of the text-book of Prof. Schmidt-Rimpler. For several years it has been used in German universities, and has been well received and become a popular work. It presents modern ophthalmology in a systematic and complete manner, alike acceptable to the practitioner, student, and specialist. A detailed review of so extensive a work would be unnecessary, but as it is divided into different parts the subjects are easily found. Since the reviewer has had his attention recently attracted to the question of amblyopia and amaurosis through two notable cases in his practice, he naturally turned to this chapter, and found it to be the most complete and satisfactory discussion of the subject in any text-book. In speaking of the different forms of amblyopia, the author says: "We may have it from traumatism. The traumatism may produce an injury of the optic nerve by a splintering of bone in the optic foramen, or it may be due to the direct contusion of the eye producing commotio retina." As to prognosis after traumatism, he says the sight may recover after complete blindness following a blow of the kind. If the injury is only partial the

prognosis depends to a large extent on the field of vision. If this is much contracted the prognosis is not so favorable as when the extent of the field remains good.

While the chapters devoted to refraction, accommodation, and the fitting of spectacles contain several confusing formula that may deter the average reader from attempting its understanding, the teachings therein are sound and safe. One of the statements in treating of myopia the reviewer wishes to approve fully, that is, in myopia, unless of a very high degree, the entire error should be corrected, and the lenses worn for all kinds of work. The only criticism I could make on the chapter taken up in the discussion of refraction, and the only notable defect in the book, is the small space given to the question of astigmatism and the proper fitting of lenses to such defects.

The editor, Dr. Roosa, has made some interesting additions, which are recognized by being embraced in brackets; the translation is most excellent. This book should be on the shelf of every specialist, and the general practitioner can consult it with the confidence that its teachings are wise, conservative, and up to the times.

J. M. R.

## Correspondence.

### LONDON LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

Attention has been drawn to the action of a low temperature upon solutions of carbolic acid. When these solutions are exposed to a certain degree of cold they become cloudy or milky, and allow their carbolic acid to separate in the form of oily globules. This is notably the case for the solution of forty-per-cent strength containing ten per cent of alcohol; it ceases to be clear at  $4^{\circ}$  C., and deposits its carbolic acid between  $2^{\circ}$  and  $0^{\circ}$  C. It is found, by using twenty per cent of alcohol, the solution remains clear at zero, C. The quantity of alcohol necessary to maintain the carbolic acid in solution appears, however, to be too high, and glycerine has been tried

with some success as a solvent for carbolic acid. A solution containing five per cent of carbolic acid, five per cent of glycerine, and ninety per cent of water remained clear at zero, centigrade, and it solidified between  $-4^{\circ}$  and  $-5^{\circ}$  C.; but when this low temperature rose to  $-2^{\circ}$  the product became liquid again, and after a little shaking formed a perfectly clear solution.

Sir John Simon, who, as chief medical adviser to the Government, was mainly responsible for the two acts under which compulsory vaccination is carried out, recently gave the Royal Commission some interesting evidence as to what smallpox did in the times before Dr. Jenner's discovery, and as to the fashion in which vaccination became general. Roughly speaking, it appears that almost every body in the last century used to have smallpox sooner or later. In the paper which Sir John Simon handed to the commission he gives a striking illustration of its effect in royal families alone. For instance, in the circle of William III, his father and mother died of it, also his wife, his uncle the Duke of Gloucester, his cousins, the elder son and the youngest daughter of James II, while he himself had suffered from it most severely. So too in the Court of Austria: In the eighteenth century it carried off Joseph I, two empresses, six archdukes and arch-duchesses, the Electors of Saxony and Bavaria, and to these may be added a Dauphin and a King of France, a Queen of Sweden, and an Emperor of Russia. The introduction of compulsory vaccination changed all this. Immediately before the passing of the vaccination acts the death-rate from smallpox was three hundred and five per million of the population, and in the last ten years it has been fifty-four per million. In the case of children, the death-rate in the first period was one thousand six hundred and seventeen per million, in the second it was ninety-four. But it is significant that, as regards persons over forty-five, there has of late years been an actual increase of deaths from smallpox. In other words, since the introduction of compulsory vaccination the

general mortality from smallpox has fallen to one sixth of what it was, and the only persons among whom there has not been an immense decrease of mortality are those born before the acts came into operation. It has been suggested that the diminution is due to the effect of sanitary improvements, and Mr. Picton pressed many of the witnesses on this point. But as other zymotic diseases are known to be much influenced by sanitation, and as there is not one of them where the death-rate among children has fallen to a fraction of what it was while actually increasing among adults, the commission apparently did not attach very much importance to the question of sanitary improvements as bearing upon smallpox. Mr. Picton adopts the theory that vaccination produces an infectious form of smallpox, and actually promotes the disease. Dr. Thorne Thorne made a telling point on behalf of vaccination, by showing that whereas nurses in smallpox hospitals who are constantly brought into contact with the most virulent cases enjoy absolute immunity, the mortality among nurses in fever hospitals is terribly large.

Some good sanitary work has been done in the chief cities of Scotland like that which is being attempted to be carried out in London. The Lord Provost and Town Council of Glasgow have just had before them the case of some blocks of dwellings unfit for habitation. Respecting them the usual statement was made: rooms filthy, ill lighted, unventilated, tenants unhealthy, and undergoing moral and physical degeneration. Out of one hundred and sixteen inhabitants there had been in seven years forty-six deaths and twenty-nine births. On the recommendation of the Health Committee the magistrates decided to pull down these reeking dens.

At the recent meeting of the Clinical Society of London an interesting case was introduced of Pott's fracture, with fracture and displacement of the astragalus, followed by symptoms of tetanus, which subsided after removal of the displaced fragment. The patient, a young man, fell fourteen feet

from a scaffolding and sustained the injuries. When first seen there was a good deal of swelling, and the limb was placed in a splint. Inflammation of the soft parts was followed by supuration, and some sloughing over the displaced astragalus. Four weeks after the injury symptoms of tetanus supervened, the parts were then explored and the displaced astragalus was removed; the bone was found to be broken across just below the lateral facets. In a day or two the symptoms subsided and the patient recovered with a useful foot. Mr. Christopher Heath said there was no doubt that wherever there was a source of irritation in tetanus it should be removed.

On Rhinophyma, or Hammer Nose, is the title of a paper by Dr. Balmaus Squire, Surgeon to the British Hospital for Diseases of the Skin, and which has been published in a separate form. The view Dr. Squire takes of rhinophyma is that it is simply one of the degenerations of advanced age, and that the affection is often hereditary. In every country artists and actors are in the habit of representing drinkers as affected with rhinophyma. But Dr. Squire points out, as a matter of fact, the "jolly nose" of drinkers is not rhinophyma, but rosacea. Although alcoholized persons are not exempt from rhinophyma, they are not more subject to it than other people. The treatment is in most cases a surgical matter. In the earlier stages it is possible to reduce the swelling by pressure (so as to express sebaceous accumulations) and by the application of red iodide of mercury ointment (fifteen grains to the ounce). When the disease has attained considerable development pedunculated excrescences may be snipped off. In other cases Dr. Squire recommends the removal of a wedge-shaped piece of skin. Complete ablation may also be necessary, and the author gives the drawing of an instrument he uses for the purpose. But, as a rule, rhinophyma gives no pain, and most elderly men would rather bear the ill they have than submit to an operation.

Dr. Collier has published a series of lec-

tures on the Physiology of the Vascular System. They were originally delivered by him at the Royal College of Surgeons, and are now issued in the form of a small but highly instructive volume. His important modification of former doctrines relating to the mechanism of the auricles and ventricles and the cause of the heart sounds constitutes the substance of Dr. Mayo Collier's lectures.

The remains of the late Mr. Haynes Walton, F. R. C. S., Consulting Surgeon to St. Mary's Hospital, have been cremated at Woking, in accordance with his earnest desire expressed some time before his death. The ashes were afterward deposited in the family grave.

A legacy of £100,000 has been left to the University of St. Andrew by a millionaire centenarian, Mr. Berry, long a resident in Australia.

The Bradshaw Lecture at the Royal College of Surgeons will be delivered by Mr. Thomas Bryant, the subject being Colotomy, Lumbar and Iliac, with special reference to the choice of operation.

LONDON, November, 1889.

## Abstracts and Selections.

**THE PULSE DURING THE PUERPERIUM.**—As a rule the pulse begins to slow down immediately after labor, and slows steadily for the first eight days of the puerperium. It is most rapid at the beginning of the first puerperal week, least rapid at its end. This slowing is equally marked in primiparæ and multiparæ, and amounts in the week to nine or ten beats per minute. Beginning at 61, it falls to 50–51. There is a diurnal variation in the pulse-curve as in the temperature-curve. The pulse is slowest at midnight and quickest at 8 A. M.; it rises most from 6 A. M. to 8 A. M. and from 12 to 2 P. M. The difference between the maximum and minimum rate any one day is on the average seventeen beats (60–77). The pulse rises after meals. The slowest pulse taken during these observations was 36, which was found on two occasions in nursing multiparæ on the seventh day. Blot and Depaul have observed a pulse of 35 in the puerperium, Olshausen and Quinquaud 34, while

McClintock has reported a pulse of 30 after the birth of triplets. This is the slowest puerperal pulse yet recorded. The main cause of pulse-slowness in the first puerperal week is probably the altered condition of the blood, while physical and mental repose is probably a subsidiary factor. Has the pulse-rate any prognostic value? As long as the pulse remains slow the puerperal patient is not suffering from any serious febrile disturbance, but as soon as febrile symptoms appear the pulse rises. If there is elevation of temperature without corresponding rise of pulse, the febrile disturbance is probably only ephemeral. Of course a diagnosis or prognosis can not be safely based upon the consideration of a single symptom; the pulse-rate must be considered along with the temperature-curve, and the other symptoms subjective and objective.

After regular labors the temperature rises continuously and reaches its maximum in six to seven hours, then it falls steadily for ten to twelve hours, and reaches its minimum sixteen to nineteen hours after delivery. The remission is greater than the rise, because at the conclusion of labor the temperature is above the normal. In primiparæ the temperature two to three hours after delivery is almost half a degree higher than in multiparæ, but in eighteen to nineteen hours the effects of the more severe labor have passed off and there is no longer any marked difference between them. After irregular labors the temperature is 0.5° to 1° higher than after regular labors, and it takes a proportionately longer time to fall to the normal. A normal temperature-curve for the first twenty-four hours is a favorable prognostic as far as it goes, but of course is no guarantee of a subsequently favorable puerperium.—*Montreal Medical Journal*.

**CASES OF INTUSSUSCEPTION CURED BY INVERSION.**—S. M., a strong young man, aged twenty-one, who resided five miles from my residence, applied to me for treatment, having congestion of bowels and kidneys, etc. After ten days he was quite convalescent, but four days after my last visit I received an urgent message to visit him, as he was taken suddenly worse and thought to be dying. On my arrival, about 2 A. M., I found him in great pain in his bowels, especially over the right iliac region, with intense thirst, retching, vomiting, tenesmus, and discharges of mucus. Pulse small and irregular; temperature subnormal; body feeling cold. On inquiry as to the cause of this serious condition, I learned that he had left his room on the previous day, and had

eaten and drank very freely, after which he was seized with excruciating pain in the bowels. The diagnosis then seemed to be somewhat uncertain as to perforation or intussusception. I gave him some pills containing half a grain of opium, one to be taken every two hours. On visiting him at 3 P. M. he was more comfortable and free from pain, but could only lie on his right side.

On external examination his abdomen was very tense and painful, with an area of dullness over the ileo-cecal valve. Nothing could be felt per rectum. I then gave him an enema, which was soon returned with an addition of mucus and stool. This gave a temporary relief. On the following morning he was visited by my son, Mr. H. Davis, who found that all the symptoms were more severe, with an addition of stercoraceous vomiting; the abdomen more tense, having a distinct tumor in the iliac region; pulse, 120; temperature, 99.5°. The diagnosis was then definite, being one of intussusception. I visited him myself at 7 P. M., when he was much worse, vomiting incessantly; countenance very anxious; pulse very small, 130. It was then evident that nothing but an abdominal section would be of any avail, but as it was then late I deferred the operation until the morning. In the mean time I would try inversion.

I had my patient suspended by his legs, but after fifteen minutes the pain in the bowels increased so much, with a feeling of faintness, that I had to desist. On his being put back into the bed he felt the tightness lessening, and, becoming more free from pain, within two hours the vomiting ceased and he had frequent involuntary discharges of stool. Twelve hours later he was very comfortable. Temperature normal; pulse soft and regular, 90. Two days later there was a discharge of blood with the stool, but since perfectly healthy, and my patient has now made a good recovery—October 14th.

Another case I had a few years ago was that of a woman, aged fifty, who, having been ill with symptoms of intussusception five days, was rapidly approaching a state of collapse. Pulse hardly perceptible, 160; countenance very anxious; severe stercoraceous vomiting; hands and feet cold. Injections of air and fluids were used, but of no service. As a last resource inversion was tried, which proved successful. As this method of treatment is not universally recommended nor tried, I think that the result of these two cases ought to teach us to employ inversion prior to surgical interference, which undoubtedly adds more gravity in these generally fatal cases.—*Dr. H. Davis, British Medical Journal.*

**TREATMENT OF DIABETES BY ANTIPYRIN.**—Dr. Joseph S. Carreau, of New York (Med. Record), cites three cases of this disease successfully combated by this remedy. He also states the fact that Dujardin-Beaumetz, at a meeting of the Académie de Médecine, April, 1888, praised the happy effects of antipyrin in certain cases of diabetes, especially when the two symptoms, polyuria and nervous irritation, predominated. Herni Huchard, at the Société de Thérapeutique, February, 1888, said that he employed antipyrin in a case of symptomatic polyuria resulting from meningocorylitis, with good effects. He gave from four to six grams daily, and the quantity of urine was brought down from thirty six liters to four. He also reported a case of diabetes, where he noticed, in a few days, the sugar diminish from 735 to 271 grams a day under the use of antipyrin—two to six grams daily. He also said that the prolonged administration of antipyrin, in his own experience, has never been followed by albuminuria.

M. Panas reported two cases to the Académie de Médecine, April, 1888, where great relief followed the administration of antipyrin. A man, aged thirty-eight, passing forty-nine grams of sugar in twenty-four hours, by taking two or three grams daily during six days, had all traces of sugar in his urine removed. A woman, aged seventy-three, by taking three grams daily for a few days, also received similar benefit.—*Canada Lancet.*

**BACILLI IN SALT FISH (RED COD).**—Dr. Alexander Edington has made a report to the Fishery Board of Scotland, in which he considers (1) the cause of the red coloration in salt fish; (2) if fish in such a condition is fit for human food; (3) what micro-organism might be present in such fish, and in others free from the red coloration; (4) if any method could be suggested whereby fish might be preserved in a dry state, free, or comparatively free, from such micro-organisms. Dr. Edington has tried to show that the cause of the condition known as the "red cod" is probably due to a bacillus, and as the bacillus was also found in the salt used for the process of curing, it was possible that the infection was carried in this way. In order to test whether this bacillus was detrimental to life, he performed an inoculation experiment. A quantity of the red growth was injected hypodermically into the cellular tissue of a guinea pig, but this was unattended with any pathological result. Two tubes of Koch's jelly were taken and mixed with boracic acid, so that the quantity of the latter present in it was three per cent. These were,

after sterilization, inoculated with cultivation of the red bacillus, at the same time that two tubes without boracic acid were also inoculated. The four tubes were then placed in an incubator for five days, with the result that the boracic-acid tubes were quite clear and sterile, while in the ordinary tubes the thick pellicle and other visible signs of profuse growth of the bacillus were present. The general conclusions drawn are: First, the method of curing cod as at present practiced is unsatisfactory, for even if these organisms, isolated, are not hurtful to man, the very fact that they grow there shows that such fish might at any moment be contaminated with organisms of a virulent type; secondly, that the salt used for curing can not be looked upon as antiseptic; thirdly, that the use of boracic acid to the amount of three per cent, while not hurtful to the material, is evidently a means whereby the fish may be kept comparatively free from putrefactive organisms. From these statements the practical suggestions which Dr. Edington would make, are: (1) That the water used for curing fish should be as pure as possible; (2) that clean salt should be used—heating the salt does not interfere with its qualities; (3) that, after salting, the fish should be dried as quickly as possible; (4) that boracic acid should be used in the curing, in the proportion of not less than three per cent of the water used.—*London Lancet*.

**THE HYPODERMIC INJECTION OF CREOSOTE AND GUAIACOL IN PULMONARY CONSUMPTION.** Induced by the favorable reports of Schetelig (*Deutsche Medizinische Zeitung*, 1889, No. 16) on the subcutaneous injection of creosote and guaiacol mixed with almond oil, Dr. Ludwig Polyák (*Wiener Medical Presse*, 1889, No. 40) determined to investigate the action of these agents in this disease, with a view of ascertaining whether the antipyretic effect which they manifested in Schetelig's experiments could not be substituted for that of antipyretics which are in common use and the administration of which frequently leads to undesirable results.

He injected these agents one hundred and seventy-six times in eight cases, and found that the minimum antipyretic dose of creosote was three and one third grains, and the largest dose he administered was seven and one half grains. The doses of guaiacol were practically the same. The antipyretic action of both was prompt. Immediately after the injection profuse hydrosis set in, and in the course of half an hour the temperature sank from one to one and a half degrees centigrade, and attained its lowest point in two hours. In one case the

temperature fell six degrees. Four hours after the injection the temperature rose rapidly to a point higher than it was before the injection, and this was accompanied by rigors. Large doses had no marked effect on the fever, when this was rising. He observed no difference in the action of the two agents. Their undesirable effects are: profuse sweatings, rigors, and sudden temperature oscillations. No collapse was observed at any time; and, although the expectoration diminished slightly in four cases, and the appetite and digestion improved in two, the author is doubtful if these good effects can be attributed to the drugs, and on the whole finds nothing encouraging in their application. Besides, their injection is very painful, and very often followed by local inflammation in the skin of the abdomen, the seat of their introduction.—*Medical and Surgical Reporter*.

**THE ARTIFICIAL FEEDING OF INFANTS.**—Cow's milk forms the basis of most of the artificial foods used in civilized countries. While most analyses of cow's milk practically agree, different analyses of human milk differ greatly in regard to the amount of casein and of sugar present. These differences he considered to be due to faulty analyses. Pure cow's milk contains three per cent or more of casein, while human milk never contains more than one per cent of casein. He advocated a mixture of diluted milk, cream, sugar of milk, and lime-water. The method of preparation is as follows: one quart of milk is allowed to stand in a high pitcher for three hours; one pint of this is then slowly poured into another vessel, thus obtaining the upper rich layer. When the child is to be fed, take of this milk three tablespoonfuls; lime water, two tablespoonfuls, and sugar water, three tablespoonfuls. The sugar water is made by dissolving eighteen drams of milk-sugar in one pint of water. He had used this preparation in private practice and in hospital practice among foundlings.—*Dr. Arthur Meigs, Boston Medical and Surgical Journal*.

**A REMEDY FOR NEURALGIA WITHOUT MORPHINE** (*Journal of American Medical Association*):

Antipyrin.....	3ij;
Ex. cannabis Ind.....	} aa gr. vss;
Ex. aconite.....	
Caffein.....	3ss;
Hyosine hydrobrom.....	gr. ½.

Divide into thirty capsules.

# The American Practitioner and News

"NEC TENUI PENNA"

Vol. VIII. SATURDAY, DECEMBER 7, 1889. No. 12.

D. W. YANDELL, M. D., }  
H. A. COTTELL, M. D., } Editors.

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## THE IDEAL ANTISEPTIC DRESSING.

The recent address of Sir Joseph Lister before the London Medical Society on a new antiseptic dressing shows that the ideal antiseptic even in surgical dressings is still undiscovered.

Little more than a decade ago carbolic acid as a wash and in the spray was in almost universal use, and was supposed to meet all the requirements of a germicide. But the microscopists soon discovered that microbes could live and proliferate in all therapeutically manageable solutions of carbolic acid, while the surgeon found, to his dismay, that the then liberal use of the drug upon wounds in general, and in the peritoneal cavity in particular, not infrequently killed his patient, while the effect upon the microbe remained in doubt.

"*Fort mit dem spray!*" (away with the spray!) from the mouth of the great German clinician was the death knell of this surgical procedure, and this, with the demonstrated low germicidal power of carbolic acid, caused the apostle of antiseptic surgery to confess the impracticability of his method, and to seek for a better way of applying some better germicidal drug.

The enemies of Mr. Lister and the old fogies who were trying hard to believe that the microbes had no existence rejoiced at this,

and immediately proclaimed the downfall of antiseptic surgery. But it was evident to such as took more sober views of the signs of the times, being slow to accept new doctrines and still slower to renounce them when accepted, that the practice of surgery had been revolutionized, and that to Mr. Lister was due the honor of the revolution. Since that time the advance of surgery along the path blazed out by Mr. Lister has been one triumphal march, while microbiology has taken its place among the fixed facts of science. In the long list of discoveries and practical uses flowing therefrom which has since passed under the professional eye the name of Lister has seldom appeared; but it is a fact well known that he has been for many years carrying on a series of investigations with the hope of finding the ideal germicide, and of devising ways and means by which it can be made to do its perfect work in surgery. Some five years ago he presented to the same society the results of his studies in corrosive sublimate. At that time he answered the objection raised on chemical grounds to this drug, to wit, that it was precipitated in wounds as an albuminate of mercury, by showing that the resulting compound not only preserved the properties of the sublimate, but that this compound, even after drying, could be dissolved in blood serum. From this came the sero-sublimate gauze, which had a definite admitted value. This substance, however, presented certain defects, and the investigator has continued his quest.

He next tried some of the double mercuric chlorides, that of mercury and ammonium (*sal alembroth*) for instance, but found them too soluble, and therefore too irritating for use in a surgical dressing. The cyanide of mercury was then tried, but while it had great power to inhibit the growth of germs it had little to kill them, and moreover proved too soluble, and consequently irritating to the wound and poisonous to the patient. The double cyanides were then investigated, and after much study and masterly experimentation he has found a most useful but not perfect agent in the almost insoluble double cyanide of mercury and zinc. This substance is incorporated with starch, with which

it forms a kind of combination whereby it can be affixed to gauze so neatly that in the dry state it does not become detached, while in the wet state it does not wash away." He claims for the gauze thus prepared that it is antiseptic, permanent, and non-irritating. While this claim would seem to state all the prerequisites of a perfect antiseptic dressing, the author still finds it to fall short of his ideal, and will continue the search.

The finding of the ideal surgical dressing and the perfect germicide would doubtless give Sir Joseph great satisfaction, but such discovery would add little or nothing to his monumental fame. He has succeeded in convincing the surgical world that surgical dirt and microbes are synonymous terms, and in putting to practical test the fact that good results in all surgical procedures go, *pari passu*, with the pains taken by the surgeon to eliminate the disturbing factor from himself and from his patient, and this is enough for one man to do, though the task consume the best efforts of a long life-time.

### Notes and Queries.

*Editors American Practitioner and News:*

There is much in what I have recently seen of surgery and surgeons in New York and Philadelphia so gratifyingly new to me that I venture to send you a few more notes of my observations.

In Dr. W. Gil Wylie I found a surgeon with many original convictions and full courage. At his private hospital in West Forty-third Street I saw him open the abdomen of a woman past fifty-five years old, much emaciated and broken. He found a very large multilocular cyst of one ovary, probably colloid, with papilomatous growths about the pedicle. This tumor was overlaid by the broad ligament for two thirds of its extent; the adhesions were extensive, and were overcome with great difficulty. The other ovary was the seat of a much smaller cyst of the same character, but removed with far less difficulty. The hemorrhage was but moderate. After the operation the cavity was filled with a weak saline solution at 1-10 per cent. A considerable quantity of this solution was per-

mitted to remain in the abdomen, a glass drain put in, and the patient brought to bed. She reacted well.

Dr. Wylie also expressed to me strong views of the treatment of appendicitis and perityphlitis, holding that as the first always and the latter frequently threatens directly general peritonitis, it is not enough to merely explore the site of inflammation, but that surgery demands a complete laparotomy, with full irrigation and careful toilet. Dr. Wylie promised a full exposition of his views and experience at an early date.

This subject reminds me that I heard Dr. Stimson read his rather remarkable paper on Gunshot Wounds of the Abdomen, since published in the New York Medical Journal. Dr. Stimson reports from New York hospital statistics, during a period of about ten years, 23 cases of penetrating (?) gunshot wounds of the abdomen treated on the expectant plan, with 15 deaths; mortality, 65 per cent. Also, from same source, 31 cases of laparotomy for penetrating wounds, with 25 deaths; mortality, 80.6 per cent. The essayist was undismayed, however, by this unfavorable showing, and recommended uncompromisingly exploration in all cases of gunshot wound at all suspicious of penetration, if seen before the development of peritonitis. The voice of the Academy seemed in accord with the view that operation after the development of general peritonitis was in the face of all hope, and could only serve to bring the treatment into disrepute. Dr. Stimson preferred the method of exploration of the wound by the knife and finger to the plan by hydrogen gas advocated by Senn. Drs. Curtis and Abbe also regarded the Senn method as less safe and satisfactory. Dr. Abbe declared against attempting to establish intestinal anastomosis in the primary operation. Dr. Wyeth would always open the abdomen in a wound below the navel, unless made by a very small bullet.

In his office I saw Dr. F. S. Dennis locate with the telephone probe a bullet that had resided for twenty-five years in the thigh, and in search of which two extensive exploratory operations had been unsuccessfully made. A very audible click announced the proximity of

the probe to the metal. The experiment was highly satisfactory, though the apparatus is so complicated as to defeat its utility, too many preliminary arrangements being necessary to admit of its employment in emergency cases, and in fact the paraphernalia of the apparatus can be got together only under most favorable circumstances.

Supra-pubic cystotomy is an operation in great favor with Dr. Wyeth. Indeed, he said to me he almost exclusively resorted to it for stone and bladder explorations as well as vesical tumors, believing it preferable to the lateral method, without regard to the character of the case. In an operation for cystitis and paralysis of the bladder in a boy he used no distension of the rectum nor any sound in the bladder. Some seven or eight ounces of boric-acid solution in the bladder prepared the patient for the knife. The bladder was well exposed to view before it was incised. A T-shaped soft rubber tube was put in, the top of the cross, of course, lying in the cavity, with the shaft protruding well out of the wound. Iodoform gauze packed around this tube, without any sutures, completed the dressing. Dr. Wyeth merely closes the bladder walls, though he does not declare against such surgery after operations where little or no cystitis is present to demand drainage. He removes the tube in four or six days (unless absolutely contra-indicated) to guard against fistula.

I fortunately witnessed, by Dr. Wyeth, the delicate steps of the operation for staphylorraphy. The cleft was wide enough to receive the finger; the child was about a year old. Chloroform narcosis, purposely incomplete, prepared the patient. After freshening the edges of the cleft in both the hard and soft palate, the operator passed a strong, sharp elevator beneath the periosteum of the palate bone, entering it near the alveolar border, and separated a surface on each side of the cleft, perhaps larger than a half dollar, thus allowing two strips of periosteum and mucous membrane, attached at each side by a broad pedicle, to slide together and close the cleft. Only the posterior part was operated on at that sitting. Though the hemorrhage was quite profuse, yet by mops on handles it was kept from interfering

seriously with the respiration of the child. If this, the most difficult part of the operation, succeeded, it was intended to close the anterior part of the cleft by a similar operation in a few weeks.

Dr. Bull is a believer in colotomy for cancer of the rectum, both as a preliminary to extirpation and as a palliative. He did an inguinal colotomy on a vigorous-looking farmer yesterday, cutting down upon the peritoneum just above Poupart's, in the left groin. The gut was carefully stitched into the small wound, and left unopened until adhesions formed. Such an artificial opening is far more easily managed than one in the old lumbar operation. This patient suffers from an epithelioma, which, while extensive and stricturing, can be dissected by the finger. A secondary operation will be made for its removal.

Dr. Gerster showed me a patient whose rectum he had extirpated some four months previous. He first took out the coccyx, and then dissected out the rectum. He did not try to draw down the bowel. The anus consequently was formed at the tip of the sacrum. Some time after a second operation was made, closing this anus and allowing an exit at the site of the old sphincter. The patient was in greatly improved condition, and had fair control of the bowel contents. Dr. Gerster much prefers this method of operation to the one of dissecting out the rectum, believing the dangers of sepsis and peritonitis to be greatly lessened by the more favorable drainage conditions.

I am much interested in a series of these operations for small, unmanageable, inguinal hernie in children under eight years. Dr. Bull dissected out the sac in one of the cases; in the other two it could not be made out. Two sutures of strong catgut approximated the edges of the rings. While Dr. Bull believed it likely these children would require some form of truss as a security, perhaps permanently, he felt sure so much comfort would be gained by the easy retention of the hernia, even if they did partially relapse, as to justify the operation. Dr. Bull is not so confident as is Dr. McBurney of the permanency of the radical cure.

Here in Philadelphia, where I stop but a day, I was fortunate enough to see Dr. Montgomery remove a fibro-cystic tumor of the

uterus, as well as both ovaries. Dr. Montgomery is a careful follower of the aseptic method.

Dr. J. Price, while a model of cleverness, does not employ chemicals on the body of the patient, though he uses the gauzes in his dressings. At a hysterectomy I saw him do to-day there was an abundance of hot water and beautiful, cleanly method. After the tumor, which weighed perhaps thirty pounds, was turned out of the abdomen and ligated, no sponges which touched it or the stump after the tumor was cut off were allowed to come in contact with the living tissues of the wound, nor even to be washed in the same basin with the other sponges. Dr. Price is a rapid operator, he believing it highly important to thus limit shock to the minimum. All through the operation he seemed in a hurry, though any thing but confused. His method was a sharp contrast to the leisurely surgery I witnessed in New York, but his wonderful results would commend any method by which they were attained.

Dr. T. G. Morton is also a rapid operator. I saw him remove the astragalus for congenital talipes varus. He is a very earnest advocate of this operation, which certainly presents a most promising immediate result, with excellent prospective motion. Dr. Morton looks on all cases of congenital talipes as due to different degrees of paralysis in intra-uterine life, resulting in more or less alteration of the shape of the tarsal bones, even before locomotion is attempted. I saw several very pretty results from operations done some months ago by Dr. Morton, and found reason to believe the amount of motion obtained after the excision of the astragalus is equal to that got by tarsectomy, or even after tenotomy in bad cases, while the simplicity of the operation and the rapidity of cure are points in high commendation in the method.

And now, as I turn to go away from these fields in which I have so pleasantly and profitably gleaned these past three weeks, my earnest gratitude to many gentlemen in the profession, both here and in New York, prompts a few last words. To Drs. Dennis, McBurney, Abbe, Curtis, Price, Montgomery, and Morton I am indebted for more than simple professional

courtesy; to Dr. J. D. Bryant for so genial and unconventional a greeting that I shall not hesitate to commend to his kindness such as are earnest in surgical interests; to Dr. C. C. Rice for courteous and valuable attentions at the Post-Graduate; to hearty Dr. R. T. Morris for valuable help in many ways. But besides these and several others, through whose thoughtful kindness I enjoyed privileges at many operations to which I have not referred, there are two whose kind personal attention I am as proud to remember as I was eager to obtain, and it is not too much to say that, had I to take home with me only the advantages obtained through the kindness and thoughtfulness of the brilliant W. T. Bull, and the unforgetting friendship of that able surgeon, John N. Wyeth, I should still account my visit one of the best repaid of my life. H. H. GRANT.

PHILADELPHIA.

**THE MURDERER'S GUILT AND THE SURGEON'S RESPONSIBILITY.**—A legal decision of considerable interest to surgeons was rendered not long since in a murder trial in Liverpool. A man named Vaughan was tried for the murder of a Mr. Godfrey, whom he had struck on the back of the head with an adze, inflicting a scalp wound behind the ear. The injured man was taken to a hospital, and there developed symptoms of compression of the brain. It was thought that the skull was fractured, and on consultation the surgeons determined to trephine. This was done, and the man died in consequence, apparently of hemorrhage from a large vessel opened during the operation. At the *post mortem* examination it was discovered that there had been no fracture of the skull. At the trial the defense claimed that death resulted directly from the operation, and was not to be attributed to the original injury. The judge ruled, however, that this claim was inadmissible, as no culpable want of skill or negligence on the part of the surgeons could be proven.

Such questions have arisen before, and are liable to be raised in any case in which the murdered man does not die within a very short time after the injury has been

inflicted. If the wounded man is saved by timely treatment, the defense is very willing to profit by the surgeon's skill, though seldom ready to acknowledge its agency. But if treatment is unavailing in saving life, it is the surgeon, they say, and not the assailant who has killed the man. There is a precedent in the English courts for this ruling, which is cited by the *Lancet* in its comment upon the Liverpool case. Edward Lawless Pym was tried at Southampton, in the year 1846, for the murder of a Mr. Hawkey, and had the advantage of being defended by Mr. Cockburn (afterward Chief Justice of England). Mr. Pym had shot Mr. Hawkey in a duel and wounded him. An operation was subsequently performed, and the wounded man died. Mr. Cockburn proposed to show that the operation performed was unnecessary, and that without it the patient might have lived. But the presiding judge, Mr. Justice Erle, after consulting with Baron Rolfe, laid it down as law that "where a wound is given which, in the opinion of competent medical advisers, is dangerous, and the treatment which they adopt is the immediate cause of death, the party who inflicted the wound is criminally responsible."

This ruling would seem to be a very just one, and, moreover, one that will ultimately be of benefit to the accused in similar cases. For the surgeon, assured that the death will not be laid to his door, can accept the responsibility of treatment with greater confidence, and the success of his efforts will not be jeopardized by nervous apprehension of failure.—*Medical Record*.

**THE PHILADELPHIA POLYCLINIC AND COLLEGE FOR GRADUATES IN MEDICINE.**—At a recent meeting of the Board of Trustees of this institution Richard J. Levis, M. D. was elected Emeritus Professor of Surgery. Charles B. Nancrede, M. D., who was recently called to the Chair of Surgery in the University of Michigan, was elected Emeritus Professor of General and Orthopedic Surgery. Charles H. Burnett, M. D., was elected Emeritus Professor of Otology. J. Solis Cohen, M. D., was elected Emeritus Professor of Laryngology.

An additional chair of Orthopedic Surgery was created, and Thomas G. Morton was elected Professor. Professor Morton will utilize the vast clinics of the Orthopedic Hospital and Infirmary for Nervous Diseases. Professor S. Weir Mitchell having for sometime past used the Nervous Department. A new Department of Dentistry was created, and the faculty was authorized to place a competent teacher in charge until the next meeting of the trustees. A new department of Experimental Therapeutics and Physiology was created, and Thomas J. Mays, M. D., was elected Professor. The chair of Clinical Surgery was filled by the election of Thomas S. K. Morton, M. D., Professor. C. L. Bower, M. D., was elected Adjunct Professor of Clinical and Operative Surgery, and J. Abbott Cantrell, M. D., Adjunct Professor of Diseases of the Skin. The chair of Pathology was left vacant until the next meeting.

A plan for the progressive endowment of free beds supplementing the present arrangement was adopted, whereby a person could, by the payment of five hundred dollars, endow a free bed for one month in every year in perpetuity. By this arrangement one month may be added at a time until a bed becomes free all the time each year in perpetuity.

The report of the Building Committee was read, in which it was stated that contracts had been signed for the preliminary work to the amount of \$23,150. About \$30,000 will be required to finish the building, and it was decided to push the building to completion as fast as the donations for the purpose could be obtained. The overcrowded condition of the present building makes it necessary to use every exertion to move into the new building in the early spring, even though it be unfinished.

The reduction of the State appropriation to ten thousand from fifty thousand dollars, the amount unanimously recommended by the State Board of Public Charities, makes it necessary to appeal to the generosity of Pennsylvanians, who will certainly aid so important an institution.

Word was received from the Ladies Aid Society that November 7th had been selected for their annual donation day, so that the laying of the corner-stone and the reception on

November 2d should be followed a few days later by the Donation Day.

Money for the new building and maintenance together with household articles for the new hospital will be gratefully received.

**THE AMERICAN ACADEMY OF MEDICINE.**—The recent meeting of the American Academy of Medicine, held in Chicago on the 13th and 14th of November, was the first one ever held in the West. Established at Philadelphia during the session of the Centennial International Medical Congress in 1876, this association has since that date been earnestly at work to promote some of the most important interests of the medical profession. Its immediate objects, as stated in its constitution, are to encourage young men to pursue regular courses of study in classical and scientific institutions before entering upon the study of medicine; to extend the bounds of medical science; to elevate the profession; to relieve human suffering, and to prevent disease. As was well said by a former president of the Academy, Dr. Frank H. Hamilton, the society seeks "to remedy a great and universally admitted evil, namely, imperfect preparation for the study of medicine and its almost inevitable sequence, imperfect qualification on the part of those who are admitted to practice." In pointing out the available means for accomplishing this purpose, Dr. Hamilton said that the society should labor to create a healthy public sentiment which shall, in a measure, influence medical colleges and medical men, and that, most of all, it should strive to create a sound sentiment among the young men who contemplate the study of medicine, and who should have clearly pointed out to them the most valuable means of enlarging their future fields of usefulness as practitioners. The Academy is not intended as a substitute for any other association of medical men, but as supplemental to all organizations which have for their object the uplifting of the profession and the enlargement of its field of useful endeavor.

The present meeting was an occasion of much interest. The addresses were of a very high order of merit, and some of them, especially that of the president, Dr. Leartus Con-

nor, abounded in statistical facts that can not fail to be of the greatest interest to medical men throughout the country.—*Journal American Medical Association.*

AMONG recent appointments of Johns Hopkins men are B. Meade Bolton (assistant, 1887-88), Director of the Department of Bacteriology in the Hoagland Laboratory, Brooklyn, N. Y.; William H. Howell (Ph. D., 1884, and associate professor), Lecturer on Physiology in the University of Michigan; Henry Sewall (Ph. D., 1879, and recently professor in the University of Michigan), Professor of Physiology in the College of Physicians and Surgeons, Baltimore.

REAR-ADMIRAL J. H. GILLIS writes from Montevideo, September 11, 1889, that yellow fever is breaking out in various parts of Brazil, also in the city of Rio de Janeiro. This indicates an unusually sickly season, and he strongly urges, that unless circumstances arise rendering the presence of one of our vessels imperatively necessary, none be permitted to visit infected ports of Brazil this year.

**AN ARSENICAL SPRING**—A remarkable occurrence is reported from Belgium, where several inmates of a newly-constructed almshouse died very suddenly and without apparent cause. Investigation revealed the fact that the water supplied to the institution, which came from a spring near by, contained 0.7 of a grain of arsenical acid to the gallon, and it has since been used medicinally as a substitute for Fowler's solution. Arsenical mineral waters have been known before, but this is the first instance on record where fatal accidents have occurred from their use.—*Popular Science News.*

DR. ISAAC E. TAYLOR, founder of Bellevue Hospital Medical College, died suddenly, October 30th, in New York City, of pericarditis, in the seventy-eighth year of his age. He was born in Philadelphia in 1812, and was graduated at the University of Pennsylvania in 1834.

# THE AMERICAN PRACTITIONER AND NEWS

"NEC TENUI PENNÂ."

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No. 13.

*Certainly it is excellent discipline for an author to feel that he must say all he has to say in the briefest possible words, and his reader is sure to skip them; and in the poorest possible manner, or his reader will certainly misinterpret them. Generally, also, a document of fact may be laid on a patient's eye, and no amount of eloquent facts at present more than any thing else. —H. A. S.*

## Original Articles.

### REPORT ON PROGRESS IN OPHTHALMOLOGY.

BY J. MORRISON RAY, M. D.

*The Treatment of Glaucoma.* Within a short time there have appeared several noteworthy articles in which are discussed the treatment of cases suffering from glaucoma. The teachings promulgated differ very much, and, as is often the case, to our sorrow, all treatment is of no avail in this disease. Nevertheless a review of these recent writings may be of value. If we follow the teachings of the majority of the modern textbooks we are sure to give a more favorable prognosis in iridectomy for glaucoma than experience would warrant. To the man of practical experience glaucoma is a disease which, while in certain cases it is amenable to treatment, often slowly progresses to complete blindness, notwithstanding all forms of treatment known may have been tried. All operative methods failing, many are now going to the other extreme and advocating the local use of myotics as a substitute for the knife. The imperfect knowledge we possess of the etiology and pathology of glaucoma has brought about this divergence of views as to its treatment. This may be cleared up through the aid of anatomical and experimental research. Yet until such a time has arrived the treatment must be empirical. The treatment now advocated is the result of appreciation of symptoms without understanding the exact morbid condi-

tions. The symptoms are all concentrated in increased tension of the eyeball, and this is just what all plans of treatment tend to mitigate. There is no doubt but that the operation by iridectomy has saved thousands of eyes; yet it is not suitable in all cases, as efforts to find other means, such as sclerotomy, Hancock's operation of division of the ciliary muscle, paracentesis of vitreous, trephining the sclera, stretching the nasal nerve, and extraction of the lens prove. It has long been observed that when the tension of the eyeball was increased, especially that produced in old persons by dilating the pupil with atropia, the use of myotics or contractors of the pupil would relieve the symptoms of increased tension. Principally through such observations the instillation of myotics, especially eserine and pilocarpine, came into use in acute and chronic glaucoma, and now it is often found that such treatment mitigates the symptoms or relieves them altogether.

A short time since Pardee, of San Francisco, reported a series of twenty cases in which eserine was used. From a comparison with operations, especially iridectomy, he says, "Until something occurs to change my mind I shall rely upon eserine in the treatment of the disease, reserving the knife for such cases as resist the drug."

C. S. Bull, in a paper before the American Ophthalmological Society, presented the results gained in ninety cases of chronic glaucoma, in all of which operative procedure in the shape of an iridectomy was done. From a reading of this carefully prepared report those who advocate immediate iridectomy in all cases of glaucoma can find but little to fortify their opinion. Dr. Bull says in simple chronic glaucoma the chief inter-

est centers in the state of the acuity of vision and the prognosis as to the result of an operation. To this end an accurate history was kept of each case for a length of time, extending in some cases over several years. The results are very far from encouraging, as the cases show vision and the visual field to be in a state worse than had been anticipated. The conclusions arrived at by Dr. Bull are most interesting, and for those wishing to read them I will refer to the New York Medical Journal of August 10, 1889. Independent of the opinion expressed by Dr. Bull, the subject was discussed at the last meeting of the Section on Ophthalmology in the British Medical Association. Mr. Jonathan Hutchinson introduced the discussion, and his ideas as to the methods of treatment can be gathered from some of his conclusions. He said, as a rule a free iridectomy is the safest and best treatment for all forms of primary glaucoma. It is well to use eserine before resorting to operation. In a small minority eserine will be found to completely relieve the symptoms, and in a still smaller the relief given may be permanent. The more absolutely simple the case, that is, the more entirely free from pain, congestion, etc., the less is there to be gained from an operation. Cases of simple glaucoma, as a rule, are not benefited by a continuous use of eserine, and the choice lies between letting the disease run its course and an operation. He also claims that although the prognosis is doubtful it is the surgeon's duty to resort to an operation in all cases in which the disease is far advanced. The operation is often followed by immediate deterioration in sight and advancing of the disc atrophy with or without recurrence of increased tension. In the discussion that followed this paper a variety of opinions was expressed. Some preferred myotics, particularly pilocarpine at first, and the operation as a last resort. Others preferred immediate use of the knife and myotics afterward.

Lezhetchnekoff, a Russian surgeon, makes a comparison of the results gained by iridectomy and sclerotomy, which present favor-

able consideration for the latter, especially in the initial stages of the inflammatory form.

From a study of the evidence found in these different papers we are forced to conclude that the treatment of glaucoma is still unsatisfactory in many cases, and that all methods fail at times. The reporter's experience has been favorable to myotics, especially in acute glaucoma, either primary or secondary, before instituting operative procedures, and in simple glaucoma especially where increase of tension is not a marked feature in its progress.

For the intelligent practitioner who is able to diagnose glaucoma, and who is not prepared to perform the operation required, the instillation of gr. 1 to 3j solution of pilocarpine murias or gr.  $\frac{1}{2}$  to 3j solution of eserine sulph. will much lessen the severity of the symptoms and hold the disease in abeyance until an operation can be performed. The operation best suited for all cases is an iridectomy, care being taken to prevent incarceration of the iris in the wound. And when this fails, incision into the sclerotic, either direct into the vitreous chamber, or, preferably, by the method of De Wecker.

*Opacities in the Vitreous.* It is taught by anatomists and accepted by experimenters that the vitreous is nourished from the ciliary body, and probably the choroid. It has therefore been believed that all disease of the vitreous was most likely secondary to disease of ciliary body and choroid. Mr. Jonathan Hutchinson, in a recent article in the Ophthalmic Review, discusses the subject of vitreous opacities. He says it will be generally admitted that the vitreous body usually suffers in conjunction with the retina; thus in syphilitic retinitis, especially, we frequently see the vitreous body become more or less opaque. Again, he says, in affections of the choroid, on the contrary, however extensive and long-standing the disease, the vitreous usually remains quite transparent. Both of these statements seem to be at variance with accepted teaching. It is generally considered that vitreous opacities are uncommon and not to be considered in con-

nection with disease of the retina. If present, they indicate that a hemorrhage has taken place or the disease extends also to the choroid. On the other hand, when choroidal disease exists one of the phenomena usually looked for is vitreous opacities, and where the latter exist without other trouble noticeable it is considered to be due to a low form of choroiditis that is not fully developed. It is now believed by our best observers that opacities occur in the vitreous without disease of any of the ocular tissues, or it may be found after severe attacks of illness, as, for instance, after recovery from typhoid fever. We are, however, not prepared to believe that extensive plastic exudation into the choroid can occur without at some stage of the process the vitreous becoming involved. In serous choroiditis which is manifested by glaucomatous symptoms, and is to our belief the pathological condition exciting acute inflammatory glaucoma, the vitreous may become hazy in a manner similar to the aqueous, but when the inflammatory process is allayed the vitreous always becomes perfectly transparent, and rarely after acute glaucoma do we find floating particles in the vitreous. In referring to some of the probable causes for opacities in the vitreous, Mr. Hutchinson, in the article referred to, considers gout as a frequent source for such disturbance, and also the long-continued use of arsenic internally. The latter is a new question, but from such authority its consideration in every doubtful case must be noted. He says one of the best indications of disagreement of arsenic is pricking of the conjunctiva with congestion and irritability of the eyes. It is also a well established chemical fact that long-continued use of the drug disturbs the nutrition of the skin and causes it to become maddy and brown. Therefore he says it is not improbable that it may disturb the nutrition of such a substance as the vitreous, and even excite inflammation of the optic nerve and retina. He gives the history of a case in which opacities of the vitreous were traceable to the administration of arsenic, and was sure he had seen

other cases due to the same cause. Since the retina lies in contact with the vitreous, the statements made by Mr. Hutchinson appear probable, and as the choroid is separated from the vitreous by the retina and has a blood circulation entirely distinct, it may yet be taught that retinal diseases are the frequent sources of vitreous opacities, but the clinical fact that they are always present in extensive choroidal disease can not be denied.

*The Use of Ascending Doses of Nux Vomica as an Aid in the Treatment of Insufficiencies of the Ocular Muscles.* In recent years great care has been bestowed upon the study of the ocular muscles and their relation to the production of asthenopic headache and many reflex nervous disturbances. For the relief of these disturbances the operation of tenotomy of the ocular muscles, complete and partial, has been strongly advocated, and in the hands of some with apparent wonderful relief. Dr. G. E. De Schweinitz, in a recent number of the Medical News, considers the subject, and says in those cases of muscular troubles in which an operation can not be performed, or having been performed, has proved insufficient, or the correcting lens combined with prism has failed to relieve the symptoms, the use afforded by ascending doses of nux vomica is often marked. It is known that lack of muscular tone in the general system is an indication for nux vomica, and naturally weakness of the eye muscles has called for its use. He reports a number of cases showing its effects. He commences on about 10 drops of the tincture of nux vomica and increases it up to 35 or 45 drops. The susceptibility to the drug increases with age. If it be given in increasing doses and pushed until physiological effects are produced, it will in certain cases afford marked relief.

It is announced that a new weekly medical journal will appear in London January 1, 1890, under the direction of Professor Germain Sée, with the collaboration of the whole medical staff of the Hôtel Dieu.

## EXCISION OF THE KNEE FOR CONVENIENCE: CLINICAL REPORT.\*

BY AP MORGAN VANCE, M. D.

The above title explains itself, the operation being done to relieve crippling, and not for the cure of any disease. Procedures of this nature involve more responsibility on the part of the surgeon than if disease were present. If a mishap should occur, the operation caused it; in the other case the cause might be in the local condition.

CASE 1. Charley Hadfield, aged seven, had been the subject of infantile paralysis since ten months of age, both lower extremities being affected; the left had spontaneously improved to such an extent that, comparatively speaking, it had become quite useful.

Many forms of apparatus had been worn and every known treatment had been tried, and, from the history, I should judge very faithfully.

By the use of these devices he has gotten about in a badly crippled way; but as the boy grew older he more fully realized his helpless condition, and kept complaining that his father would not have any thing at all done for his relief.

The case came under my observation three years before its last appearance, and I had then advised the operation afterward done. The father, remembering this, came again and consented to it after understanding its full gravity and assuming his share of the responsibility.

I went so far as to let him hear a discussion upon the propriety of this form of operation by the members of the Medico-Chirurgical Society of Louisville, which was not at all favorable to its performance.

On October 21, 1884, after an open splint, made of leather and hard rubber, had been prepared, the operation was done in the presence of a number of professional friends, Dr. J. M. Ray administering the ether.

The limb was greatly deformed, the leg flexed, rotated, and partially luxated outward and backward. On account of this deformity, the first step in the opera-

tion consisted in making an incision longitudinally along the inner border of the patella, having for its center the joint. Before turning the bones out to be sawed off, the patella was removed, then the ligaments were divided and the ends of the femur and tibia easily exposed and removed with an amputating saw. There was no hemorrhage, as the sawing closed the cancelli. The external hamstring was left untouched, it being the only muscle of the thigh which had any vitality left, and by its contraction had produced luxation and rotation of the tibia. This muscle served as a perfect tension band to hold the bone in apposition.

There was little or no shock following the operation, and the limb was at once placed in the splint. Ten hours after the patient was placed in bed the temperature was found to be 105° F. Reasoning that nothing but malaria developed by surgical procedure could produce such a fever as this in so short a time, quinine was used liberally with the effect desired; it had to be kept up for a considerable time.

The boy suffered little during his convalescence, but was confined in bed for eight weeks before the wound closed; during this whole time there was an excessive discharge of synovial fluid. His general health was much improved, thinness and paleness giving place to increased weight and a healthful color.

The only accident occurring during his convalescence was at about the end of the third month, when the wound and counter-opening reopened completely, following the formation of pus.

The child had been walking about with the convalescent plaster dressing still on, and had probably bruised the limb, or there was slight exfoliation of bone, causing the pus formation, which, being confined under the dressing, forced the wound open from end to end, instead of discharging, as is usually the case, from a small opening at the point of least resistance. Rapid healing soon took place, and the boy has since been perfectly well. Firm bony union now exists at the site of the knee; the boy is able to stand without the aid of crutch or support of any kind, and can walk quite well.

\* Read before the Mississippi Valley Medical Association, September, 1889.

The long confinement produced weakness of the left limb, but this is fast gaining strength by use. The action of the hip is pendulum-like, as there is little or no power to flex the thigh. The foot in this patient was in a state of equino-varus, and was straightened during his confinement. If a proper shoe is worn, no operative interference will be needed, as was at first anticipated.

March 1st: This boy has been walking without aid of cane for four years, and has no trouble; the right limb, as he states, is the best of the two.

CASE 2. Harrison Daughy, aged thirteen. This boy was the subject of an old inflammation of or about the right knee, commencing ten years ago, resulting in the formation of pus, which found exit at various places and at various times, there being at one time twenty-two openings discharging. The drain continued about three years, leaving the knee in the condition in which I found it. The knee was flexed to an angle of  $135^{\circ}$ ; there was no power to voluntarily extend it, nor could passive extension be made beyond this angle ( $135^{\circ}$ ). There was passive and voluntary flexion over an arc of probably  $60^{\circ}$ . The patella was fixed so far as could be determined. The tibia was rotated in its relationship with the femur. As in the previous case, there was great atrophy, but little or no real shortening. The whole region adjacent to the joint was a mass of old cicatrices; even far down the shin and above the joint were these scars present. One large scar involved the tendon of the quadriceps muscle so completely that the power of extension would have been impossible had the patella been free.

The question of amputation *vs.* excision came up. I freely confess that had the patient's position in a worldly way been better I should have advised the former operation, but the inability to get prothetic apparatus decided the latter and more serious operation. Excision was done on January 21st at the Norton Infirmary, Louisville, under the strictest antiseptic precautions, Dr. W. W. Senteny administering the chloroform. The transverse incision was made, and after the patella was removed the ends of both tibia and femur were sawed off and fitted closely together, a set of

three chromated gut sutures being inserted through periosteum and bone to fix the bones in relationship. I think this idea can be utilized in this class of work, and may be better in some respects and just as efficient as the fixation nails or pegs of ivory. A narrow ellipse of skin was removed, and the wound of the soft parts was closed with ordinary gut, two short rubber tubes for drainage being inserted, one at each angle of the wound. The boy had no shock, and progressed astonishingly well. The tubes were removed the seventh day. The primary splint was changed for a continuous plaster splint at the end of the third week. The wound has been aseptic throughout, no swelling occurring whatever. When the splint was removed there was a little slough at the outer angle, and a small granulating spot at the inner where the tubes had rested. On the 31st day, when a large fenestra was cut, there was a small quantity of pearly-like material on the dressing, with no odor. I took this to be either synovial fluid or non-infected pus, so to speak. There seemed to be quite firm union between the bones. The temperature in this case was  $103^{\circ}$  in the mouth on the fourth day, there being two degrees difference between axilla and mouth. There was no sign from the wound, and the temperature returned to and remained at normal after the first evacuation of the bowels. I am sure this elevation had nothing to do whatever with the wound, but was due to some derangement of the digestive apparatus.

The most important lesson taught by these two cases is the difference in the history of each after the same operation, the first running the ordinary course of an infected wound—patient being confined to bed for eight weeks—and afterward with a re-opening of the wound; the other patient being practically convalescent and able to sit up after the first week, and able to take a car ride on the thirty-first day. He has walked about on crutches since the twenty-first day.

The first operation was done under the ordinary precautions practiced four or five years ago, the other under strict antiseptic precautions.

The outcome of the cases, so far as the limbs

are concerned, certainly justifies the means, as by these procedures the patients are permanently benefited, and from burdens on society are converted into self-supporting and comparatively useful members.

June 1, 1889: Since this patient has been discharged, and all dressings removed, superficial sloughing of two of the old scars has occurred, probably from tension; the points are remote from the operative wound, and the ulcers very superficial.

August 31, 1889: The ulcers are healing, and the boy has been walking without a cane for more than a month.

LOUISVILLE.

### INTUBATION.\*

BY WILLIAM CHEATHAM, M. D.

*Clinical Lecturer on Diseases of the Eye, Ear, Throat, and Nose, University of Louisville.*

Since returning home (September 13th) I have had five cases of intubation, with three successes, three of the cases having diphtheria; the fourth being a case, I suppose, of catarrhal croup. This case of catarrhal croup appears to be the slowest of the four in getting well; it was the first of the four tubed, and, it appears, will be the last to recover. This case was one of Prof. Anderson's, a child two years old. It was tubed October 17th, about 9 p. m. The little fellow had been sick since October 14th; when I saw him he was thoroughly cyanosed. It looked as if he would hardly live until we could make the necessary preparation. The tube was gotten into position on the second attempt, and relief was immediate. The tube was worn until the afternoon of October 20th, when the child was chloroformed and it was removed.

Case No. 2 I saw with Dr. Larrabee at 2:30 p. m., October 24th. This was a case of diphtheria. The child was seven years of age, thoroughly cyanotic. The tube was introduced without difficulty; relief immediate. On the morning of October 27th the little fellow coughed the tube up. His recovery has been uninterrupted, as I was informed by Dr. Larrabee the last time I saw him.

The third case was in the person of a little girl, aged five, a patient of Drs. Clemens and Bailey. She had been sick for some days. I had seen her about three days before I tubed, and the laryngeal complication was then on. The little one had from necessity to be somewhat neglected, as the father was down with typhoid fever, the mother with some continued fever, while the baby and the grandmother were both sick. At 10 p. m., October 25th, I was called to tube; her pulse was exceedingly feeble, skin blue; in fact the little one was so far gone as to give none of those more distressing symptoms of laryngeal stenosis. For a time I was in doubt of the correctness of Dr. Clemens' diagnosis. During the day she had had several severe paroxysms of cough, the nurse thinking each one would surely prove fatal. I first endeavored to introduce the tube for a four-year-old child, but failed after several attempts. The tube would enter probably half its length, but go no farther. I then used the tube for a child two years old, which entered after great resistance, necessitating considerable force. This gave some relief, but not enough. In five minutes the tube was coughed up. I then tried again the tube for a child four years old. With much force, after several efforts, this was entered. In a few moments it was coughed out. I now, with some difficulty on account of the stenosis, introduced the tube for a child of her age. This stayed in position, but did not give relief satisfactory to me, as there appeared to be some flapping of the membrane against the distal end; with this the lung may be filled, and of course if the tube becomes obstructed it can be coughed out. Whisky was given several times hypodermically.

The patient the next day was doing well. November 1st the tube was removed, leaving the patient entirely relieved of the stenosis.

The fourth case was the child of one of our local physicians. When I was called, at 4:30 a. m., I telephoned immediately for a coupé. The company from whom I ordered the coupé, I understand, has is-

\*Read before the Louisville Clinical Society, November, 1889.

sued strict orders against rapid driving by any of its employes. I was therefore a long time in getting the vehicle, and much longer reaching the house. When I arrived I found a malignant case of diphtheria in the last stages of croup. The little fellow was four years old and had been sick but two or three days. The night previous he was very cheerful and playful. He awoke his mother that morning by knocking on her bed. She found him breathing badly. All of their grates having been fixed for natural gas, and the gas turned off by the company, there was no fire in the house, and I suppose the child caught cold. I introduced the tube three times with no relief. The case continued to progress for the worse, until finally I decided to perform tracheotomy. This I did very rapidly under many difficulties; the father was compelled to hold the child; the nurse who attempted to assist fainted, falling on the floor by us. The operation was done with loss of but little blood, as the heart had nearly stopped beating. There was very great cervical adenitis. On opening the trachea the intubation tube was found in position, and extending some distance below the site of the incision. The child died just after the operation was finished. I think the death was as much if not more the result of heart failure than of failure of respiration from mechanical obstruction.

These four cases make a total of 32, with 10 successes. I had but one success in my first 15 cases; that was in the fourth case; 8 in my next 15, with one success and one failure in my third series. I am sure I have tubed two fatal cases of pneumonia with diphtheria in which the larynx was not involved, operating on both cases under protest, test, and I have had two more cases of heart failure under the same circumstances. My cases have all been operated upon in the last stages, one of them being practically dead, the family having sent us word that the child was dead; not to come. It was at least half an hour before this child was restored under artificial respiration and numerous hypodermics of whisky. This child

lived some hours, and died of heart failure while sitting up in bed playing with a watch. I speak of these cases because many physicians say those who practice intubation choose their cases and tube early.

LOUISVILLE.

## EMPHYSEMA.

BY E. S. MCKEE, M.D.

*Varieties.* Virchow\* accepts the classification of Laennec, who describes two kinds of emphysema, the vesicular and the interlobular.

*Etiology.* Lachkievitch† says that the exaggerated curvature of the vertebral column plays an important part in the causation of the disease. If from any reason there is excessive deviation of the thoracic portion, as a consequence there will be found an augmentation of the anteroposterior diameter of the thoracic cavity, and a large expansion of the lungs with a consecutive diminution of their elasticity, dilatation of their alveolæ, insufficient ventilation, dilatation of the pulmonary vesicles, slackening of the circulation, augmentation of the pressure in the pulmonary arteries, increased labor and hypertrophy of the right ventricle of the heart. Other things of course aid the work now begun.

*Pathology.* Virchow‡ exhibited specimens of emphysematous lungs to the Berlin Medical Society. These showed absence of pigmentation, which he termed an albinian condition of the lung. In the *post mortem* room he sometimes finds that that portion of the lung which is emphysematous is quite colorless, the pigmentations being entirely absent. He thought, without necrotization or destruction of the tissues, it was impossible that the pigmentation once deposited there should be made to disappear. Yet one of the lobes of the lung presented had no pigment, and was in marked contrast to the other lobe. It is well known that the deposit of carbon is very slight before the fifth year, and that this condition dates from that period.

\*Bull. K. Soc. Wiesbaden, 1877.

†Klin. Wochenschr., 1891, 18, 1000 (Lachkewitch).

‡Bull. K. Soc. Wiesbaden, 1877.

riod. He could not think that there was different expiration previous to the fifth year, for this would favor the deposit of carbon. He thought there must have existed a faulty condition of the canal introducing the air through which the carbon was hindered in passing. It is well known that during the first quinquennium there occurs thickening of the mucous membrane and walls of the bronchial tubes, by which means the bronchi are reduced in caliber. Thus we understand why the carbon contained in the air which is inhaled is retained in the upper parts of these bronchi and is again expectorated with catarrhal sputa; in this way it fails to reach the alveolæ. The distinguished speaker recommended the phenomena to the attention of his hearers, and also the proposition whether emphysema in many cases did not date back to a very early age. He asked the question whether this theory was not based on sound anatomical foundation. Professor Virchow had never found tubercles in a lung the seat of emphysema. In only one instance had he found pneumo-thorax.

*Symptomatology.* Gerhardt\* describes four cases of emphysema of the mediastinum occurring in his clinic in Berlin. An important symptom of diagnosis in all of them was a fine bubbling crackling, like that of pneumonia, synchronous with the action of the heart. This crackling is evidently caused by a displacement of the air bubbles in the mediastinum by the motion of the heart. It is heard in the whole cardiac region, but can not be felt by the hand. There is a disappearance of the cardiac dullness, and in its stead an abnormally loud, sonorous, somewhat tympanitic percussion sound. The visible and tangible apex-beat disappears and the intercostal sunken spaces fill up. The diagnosis of this condition is much easier when a skin emphysema is also present. It is usually not a dangerous complication.

*Treatment.* Rolleston† reports a case occurring in St. Bartholomew's Hospital, in which a patient suffered from advanced

emphysema, slight bronchitis, and dilatation of the right side of the heart. On two occasions, when a one-dram dose of paraldehyde was administered, he suffered severely from dyspnea and collapse, dying after the second dose. It appears that the drug is not without danger in cases where the respiratory center is depressed and some degree of cyanosis is already present.

Wood\* in his experiments found that toxic doses produced death in frogs by paralysis of the respiratory center. Thirty-five or forty-five grains caused profound sleep in a rabbit, with progressively diminishing respiration, and at last death from asphyxia without convulsions.

Rossbach's\* chair can be worked by the patient or an attendant, and affords great relief. It is of the ordinary wooden variety, without arms and with straight back. The seat is prolonged backward about three inches, and two horizontal brackets are attached to the top rail. These support two wooden cylinders about three inches in diameter and as long as the back of the chair. These are placed on each side just without its outer rail. These revolve on iron pins which pass through the projection of the seat and the brackets respectively. At the bottom of each is attached a lever or wooden handle of convenient length for the patient to grasp with his arms extended. When drawn forward parallel to each other the cylinders make a partial revolution. A broad band of strong webbing passes across the chest of the seated patient, and is attached by eyelet holes to a row of studs on the inner face of the two rollers; therefore, on pulling the handles forward the thorax is compressed to any extent which may be thought necessary. The bandage is divided in the middle and is fastened in front as a corset. The patient seats himself in his chair well back, the levers are drawn outward, and the belt adjusted so as to press equally over the thorax, and is fastened to rollers on either side. Extending his arms, he grasps the handles, takes a deep breath, and as expiration commences pulls them

\*Berl. Klin. Wochenschr.

†Practitioner.

\*Therapeutics

†Vratch.

slowly forward, the act completed, he pushes them somewhat quickly to their first position, takes another deep breath, pulls them gently together again as far as he finds necessary, and so on. Here we have artificial respiration with an automatic operator. These movements are timed and persisted in as long as the physician may direct, fifteen times per minute for ten minutes, three times a day. This instrument equally compresses the chest; the patient can use it, when once adjusted, either day or night; any carpenter can make it, and it is very cheap. It can be used simultaneously with other forms of physiological treatment, such as Waldenburg's cabinet, or combined with the use of expectorants and cardiac tonics.

Berdez\* believes that in some cases the respiratory act is imperfectly performed because the intra-abdominal pressure is insufficient; in other cases because the elasticity of the lungs is defective, and consequently the diaphragm does not relax to its full extent on account of the resistance they offer. Believing this theory, he thinks good will be accomplished by keeping up some pressure on the abdominal walls by means of an abdominal belt, somewhat similar to that employed by gynecologists. This will sustain the intra-abdominal pressure, and during inspiration enable its contents to cause the movement of the lower ribs, while during expiration they will push up the diaphragm and compensate for the defective elasticity of the lungs.

Lachkievitch† says that the best remedy for this disease is gymnastics.

CINCINNATI, O.

### CYSTIC KIDNEY MISTAKEN FOR MALIGNANT DISEASE OF THE BOWEL.‡

BY J. B. MARVIN, M. D.

The diagnosis of abdominal diseases is confessedly difficult. I report the following case as illustrating in a striking manner how an autopsy may prove how wide of the truth a diagnosis may be. The patient was

in the ward of the Louisville City Hospital in charge of Dr. Waulner. After reading the clinical history as recorded by Dr. Allison, the *interne*, I unhesitatingly diagnosed a tumor of the pylorus, and used the patient as the subject of a clinical lecture before the medical class.

Joe Pivarro, aged sixty-seven, Italian, entered the Louisville City Hospital December 6, 1888. Family history unimportant. Three brothers and sisters in good health; one died of some stomach trouble. Health of the patient has always been good until two months ago, when he had eight chills of the tertian variety. A month later he passed bloody stools. These came on every two or three days. No tenesmus, no tormina.

About this time he first noticed a pain in the epigastric region, this pain being worse just after eating, and was described as a grinding, gnawing pain and fullness, which was relieved by emesis and by pressure made by the open hand. A tumor was made out just above and a little to the right of the umbilicus; no distinct line of tympanitis between it and liver margin. An aspirator needle was inserted, but only a little blood was obtained. Constipation was the rule with edema of the lower extremities and scrotum, and a desire on part of patient to make pressure over the stomach. When pressure was made by the physician he was thrown into a pseudo-asthmatic attack with Cheyne-Stokes' respiration.

Chemical examination shows absence of hydrochloric acid in the stomach. Examination of urine showed the specific gravity to be 1028, albumen one per cent, no casts, acid; amount passed 28 ounces. There was a mitral systolic murmur, the lungs slightly emphysematous. Marked cachexia. The condition of the patient improved largely during the winter months; the edema of the lower extremities, the respiratory symptoms, the pain in the pyloric region, and the fullness all improved, and the patient left the hospital in March, thinking he was well.

He went back to his work, being a laborer in a stone quarry, but returned to the hospital April 20, 1889. He now complained of

\*Revue Medical.

†Rousskaia Medicina (Le Bulletin Medical).

‡Reported to the Medico-Chirurgical Society, Nov. 1, 1889.

pain, even great distress after taking food, with an exaggeration of all the old symptoms, constipation, chronic edema of lower extremities (lasting during the remainder of patient's life), feeling of suffocation, frequent micturation, small in quantity, anorexia; temperature throughout whole course of observation between 96.5° and 98°, usually about 97.2 to 97.6; pulse, 88 to 96. The patient slept with his head very high, and late in the course of the disease he complained of great pain and fullness over the abdomen, and was afraid to get in the recumbent position on account of difficulty in getting his breath.

The autopsy was made for me by Dr. Weidner.

"Antonio Pivaro, died June 28, 1889. Rigor mortis marked; the peritoneal cavity contained two pints of straw-colored fluid; bowels normal. The left pleural cavity contained forty-one ounces of serous-looking fluid; the right about eight ounces of bloody serum. The pericardium contained eight ounces of clear fluid; the left lung emphysematous, marginal, light in color, and the right also light in color, with a yellowish exudation from the bronchial tubes on squeezing; combined weight forty-five ounces. The spleen was lobulated, firm in consistence, of dark slate color, and weighed twenty-two ounces. The left kidney almost entirely gone; the kidney structure proper hard to make out, but in its place a cyst containing two pints and a half of clear fluid was found. All that is left of the left kidney is the fibrous skeleton, total destruction of the medullary portion and almost the entire cortical part having taken place, leaving a rind of mostly fibrous capsule and a small amount of real kidney structure; the fluid contents clear, no deposit. Ureter on the corresponding side totally occluded about one half inch above its entrance into the bladder, no cystitis, no stricture. The right kidney weighed ten ounces; congested, nodulated, capsule adherent; mucous membrane of stomach pigmented at cardiac end, dark red; soft papilloma at greater curvature; some small pigmented nodules at pyloric end. Pancreas

enlarged. The heart cavities enlarged, but walls not thickened; the right auricle as large as a ventricle. All the valves were thickened and the left ventricle hypertrophied (true); weight twenty-two ounces."

LOUISVILLE.

### EARLY TRACHELORRHAPHY AS A REMEDY FOR SUBINVOLUTION.\*

BY THOMAS S. BULLOCK, A. M., M. D.

During an extensive service in the Maternity Hospital, of New York, examinations on the tenth day after labor were made with special reference to the condition of the cervix uteri. In this time several hundred patients were examined, and a considerable proportion were found to have sustained lacerations of varying degrees. Of course, at this early period after delivery the rents appear much larger than they do at a subsequent examination. In looking over my case book I found many instances of extensive tears, noted at first examination, entirely healed a month or so later. With these, of course, we have nothing to do. All cases, as soon as the lochial discharge ceases, are put upon treatment. Hot douches of half an hour duration, three times a day, together with tampons of glycerine, etc., produce a wonderful change upon the tear, and in many cases do away with the necessity for operation. Quite a number of cases, however, do not terminate so favorably, and it is of these that I desire to speak particularly. Not much in regard to early operation has heretofore been written. The immediate operation is sometimes performed, but only to check excessive hemorrhage from the torn cervix. By early trachelorrhaphy I mean operation within from two to four months after labor, and upon those cases only which have resisted the line of treatment above alluded to—the subinvolution continuing, and the tear unhealed. Operation at this time is extremely easy. There is no cicatricial tissue to remove, and the denudation is easily accomplished without the aid of a tenaculum to catch up the

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tissue. The sutures are easily introduced, and the administration of an anesthetic may be dispensed with, an injection of cocaine rendering the whole procedure painless. The hemorrhage should be allowed to continue as long as possible, as it is extremely beneficial. The only danger to be feared is cellulitis. This can be avoided by operation upon the uterus *in situ*. Many operators dispense with the wire twister, needle holder, etc., and draw the uterus down to the vulva. This should not be done. As little manipulation as possible is the *sine qua non*. It is very generally admitted that the importance of cervical lacerations as a factor in uterine disease has been greatly exaggerated; but most of us will agree with Drs. Wells and Mundé and not with Noeggerath's conclusion, that "cervical tears have no influence upon the development of uterine diseases, that they increase the liability to conception and diminish the chances of miscarriage, and that Emmet's operation is never indicated and can have no influence on the condition of the uterus." As Dr. Wells says, in referring to the subject in the Annual, such sweeping assertions from such a source excited wide-spread attention and criticism. In replying to which he recedes somewhat from his original statements, and says he did not say the operation would not cure the conditions named, but that the tear did not cause them. In a *résumé* of the subject Houzel says the operation is so beneficial and safe that we are not justified in depriving a patient of its benefit. Such is the opinion of the authorities in the United States and elsewhere, except some in Germany. My experience has led me to believe that all tears of the second and third degrees should be repaired as early as possible. Mundé considers the operation advisable in twenty-five per cent of all cases of laceration, and absolutely necessary in twelve and one half per cent. By the early operation the patient is spared much pain and inconvenience, and at least a remote danger of developing carcinoma uteri. I have done the early operation frequently, and in each case have been very

much pleased with the result, never having failed to give relief. The subinversion disappears in a short time, and with it all the pain and inconvenience complained of. If the only good defense were the decreased danger of cancer, I should continue to do and advise the operation.

LOUISVILLE.

## SOCIETIES.

### THE SOUTHERN SURGICAL AND GYNECOLOGICAL ASSOCIATION.

(Continued from page 394.)

Dr. B. E. Hadra, of Galveston, Tenn., read a paper entitled The Open Abdominal Treatment, in which he said that abdominal surgery, notwithstanding its immense progress, has not as yet given even a moderate degree of satisfaction in acute diffuse septic peritonitis. Chronic infectious processes offer much better prospects for surgical interference, such as tuberculosis, actinomycosis, and the recently described microbial peritonitis of as yet unknown origin.

The points making the diffuse septic peritonitis are:

1. The extensive area of peritoneal surface with its enormous power of resorption of the poisonous fluid.
2. The active secretion into the sac, and thereby furnishing cultivating fluids for the germs.
3. The ready absorption by the lymphatics of the diaphragm.
4. General distribution of the poison by intestinal peristalsis.
5. The infection of the intestinal walls from without, and the additional infection of the peritoneal cavity by transudation and immigration of germs from the inside of the bowels.
6. Distension of the bowels, increasing the pressure and resorption.
7. The impeding effect of this latter condition upon respiration, defecation, and secretion of urine, leading to systemic poisoning by retained products of excretion.
8. In perforative cases the contamination by fecal matter. In stab and gunshot wounds

by other impurities, bile, urine, etc., and above all, contaminated blood.

The indications for treatment, besides supporting the patient's strength, relieving suffering, giving proper action to the bowels, kidneys—in short, besides the general medical treatment, are:

1. To remove the obnoxious material, germs, fecal matter, and urine.

2. To prevent its new formation or a repetition of its entrance, the sac should be kept dry to deprive the germ of its soil. The breaks have to be mended so that the channels of contamination may not lead to the outside.

3. To prevent the bowels from distributing the poison throughout the whole cavity.

4. To counteract pressure and suction in order to prevent resorption of the poison.

5. To prevent infection of the peritoneum and the bowel.

6. To relieve pressure in order to avoid disintegration and paralysis of the different structures.

7. To free respiration, defecation, and urination, with tympanites as developed.

Dr. L. S. McMurtry, of Danville, Ky., read a paper on Twenty Consecutive Cases of Abdominal Section.

The series of cases comprised the first twenty abdominal sections performed by him, and illustrated a variety of pathological conditions and diverse complications. All the cases were in private practice, and with two exceptions all the operations were done at the homes of the patients. Two cases were treated as private patients in a well-appointed hospital. In many cases operative treatment was only accepted after all ordinary and so-called conservative measures had been exhausted; and in several cases the operation was only accepted when the patient's condition was regarded hopeless by physician and family. In no case, however desperate or complicated, was an operation refused.

Dr. McMurtry said: Thorough work, irrigation, and drainage, all conjoined, give the only basis of success in the cases reported. In a number of his cases he had operated in

the midst of active peritonitis, with vomiting and tympanites. In this condition of affairs he had witnessed the most gratifying results from persistent and oft-repeated exhibition of calomel, dropping two or three grains on the tongue every hour until the bowels were freely moved. Increasing experience has impressed him more and more with the difficulties of abdominal work, and makes him less confident of meeting often with simple cases.

He closed his paper with a plea for earlier interference in abdominal diseases. When operations are done in good time, before emaciation and exhaustion come, and before repeated attacks of peritonitis have complicated the comparatively easy task for the surgeon, then will the surgeon's results excel even the brilliant records of the present time.

Dr. Richard Douglas, of Nashville, read a paper entitled Complications Occurring in the Clinical History of Ovarian Tumors.

Dr. G. Frank Lydston, of Chicago, Ill., read a paper on Tropho-Neurosis as a Factor in the Phenomena of Syphilis, in which he called attention to the relation of disturbances of the trophic function of the sympathetic nervous system, which the author claimed were the essence of all the phenomena of syphilis. He said: The relations of certain syphilitic phenomena to organic or functional disturbances of the nervous system, and particularly the sympathetic system, are manifested here and there along the whole line of morbid phenomena developed in the course of the disease. Syphilitic fever is undoubtedly dependent upon the action of a special poison upon the sympathetic nervous system. From what we know of the trophic functions of the sympathetic, we are justified in inferring that the majority of fevers are dependent upon the action of a specific poison upon the sympathetic ganglia. The syphilitic poison may produce disturbances of the sympathetic with perversion of tissue metabolism and excessive production of heat. The inconstancy of the syphilitic fever is explicable upon the ground of idiosyncrasy. The syph-

ilitic roseola has been demonstrated to be an exception to the rule that syphilitic lesions are due to a collection of proliferating cells. It is due to vaso-motor disturbance with resulting dilatation of capillaries. This nervous disturbance is dependent upon the impression of the syphilitic poison upon the sympathetic ganglia. The accumulation of cells in the more pronounced lesions of syphilis is simply an exaggeration of the normal process of tissue-building. As is well known such tissue-building is presided over by filaments of the sympathetic nerves.

The symmetry of the peripheral phenomena of syphilis is suggestive of some casual condition affecting the central nervous system. As an illustration of the manner in which a nerve lesion could produce disturbed nutrition, the author mentioned herpes zoster. Some of the lesions of syphilis which are difficult of explanation upon mechanical grounds, that is, upon the theory of localized cell accumulation, are readily explicable by central or local nervous disturbance. For example, the alopecia of syphilis is similar to that which occurs in other diseases as a consequence of local and general malnutrition incidental to disturbed nervous supply, as, for instance, alopecia areata, the alopecia produced by fevers, and the alopecia produced by neuralgic affections of the head. That the nutrition of the hair is profoundly affected by nervous disturbances is shown by the result of fright in producing blanching of the hair.

One of the principal arguments in favor of the theory that tropho-neurosis is the foundation of syphilitic processes, is the peculiar action of the disease when it attacks certain parts, syphilis seemingly possessing the power of dissecting out definite portions of osseous tissue (apparently by cutting off their nutritive supply) in a manner as cleanly as it can be done by the knife. Thus the speaker has in his possession specimens of the intermaxillary bone, portions of the alveolar process of the maxilla, the palatal and nasal processes of the superior maxilla, the malar and ossæ nasi which became necrosed and were removed from cases of late

syphilis. These fragments present as natural a conformation as in their healthy condition. The ordinary explanation of destruction by pressure of syphilitic exudate will not suffice in these cases. If they be observed carefully, it will be found that the first symptoms experienced by the patient are those identical to the presence of a foreign body, that is, dead bone in the tissues. If pressure were the cause of the necrosis, the death of the bone would be preceded by more or less painful swelling and inflammation.

He claimed that all of the pathological processes incidental to syphilis are due to disturbances of nutrition produced by the impression of the syphilitic poison upon the sympathetic nervous system, and that it is immaterial to the cogency of this theory whether the poison of syphilis be a microbe, degraded cell, or chemical poison. If any attempt has been made to show that tropho-neurosis is the basis of all syphilitic phenomena, the author is not aware of it.

Dr. John Brownrigg, of Columbus, Miss., read a paper on Gunshot Fractures of the Femur, in which he discussed the class of cases requiring amputation, and those in which a more conservative course should be pursued. He exhibited several appliances devised by himself.

Dr. Hunter McGuire, of Richmond, Va., read a paper on The Treatment of Cystitis in Woman, which was followed by a paper on The Treatment of Contracted Bladder by Hot Water Dilatation, by Dr. I. S. Stone, of Lincoln, Va.

During the past few years certain protracted cases of cystitis, occurring chiefly in women, have been observed by Dr. Stone, which have resisted all known forms of medical treatment, and necessitated some surgical or mechanical measure of relief.

He describes the manner of dilatation as follows: "The patient is given morphia sulphas, grain  $\frac{1}{2}$ , atropia sulphas, grain  $1\frac{1}{2}$  to  $2$ , hypodermically. She is placed on her back on a table for convenience, although it would answer to arrange the bed with the patient thereon to suit the operator. A soft cath-

ter is at once inserted into the bladder, and after the urine has escaped, hot water, temperature  $110^{\circ}$ , is thrown into the bladder until the patient will no longer bear it. This is allowed to escape, and is measured, giving the full size of the bladder in its present condition. As the morphia gradually becomes absorbed the patient will bear still further distension, each time perhaps one dram may be added to the capacity of the bladder. I prefer using a rubber ball syringe, holding two to four ounces. The pressure of the hand is safer than that of the tube or funnel, or any instrumental gauge, as the patient generally is able to resist the tendency to strain, owing to the tenesmus produced by the expansion. As each seance should continue thirty to sixty minutes, the bladder may be filled and emptied many times, and at first the operator must be well satisfied if the gain is only one or two drams in a bladder whose capacity is perhaps only two ounces. As the patient becomes fully under the influence of the morphia the water may be increased in temperature to  $120^{\circ}$  or  $125^{\circ}$  F. The very best effect follows its use when at this temperature."

\* These papers were discussed by Drs. Lydston, Davis, Engelmann, Roberts, Brokaw, Hadra; closed by the essayist.

Dr. Bedford Brown, of Alexandria, Va., read a paper entitled *Remarks on Certain Obscure and Minor Forms of Pelvic Cellulitis Simulating Malarial Fever*.

By referring to his note-books he found some twelve cases of pelvic cellulitis, some of a grave and others of a minor form, but all so very obscure in their manifestation of the presence of local lesion as to be well calculated to mislead and to cause a mistaken or false diagnosis to be made of malarial fever. There was nothing in these cases to call attention to the pelvic organs. He has in a number of instances seen these cases run their course from beginning to end without manifesting the first symptoms of local disease in the pelvis, so that the resemblance to malarial fever was very nearly complete.

Dr. Joseph Taber Johnson, of Washington, D. C., presented a paper entitled *Observations Based upon an Experience of Seventy-two Miscellaneous Abdominal Sections*.

Of this number twenty-nine were for the removal of ovarian tumors varying in size from one to sixty-four pounds, twenty-six recoveries, and three deaths; twenty-nine cases of removal of the uterine appendages, with twenty-seven recoveries, and two deaths; seven supra-vaginal hysterectomies for large uterine fibroids, with three recoveries, and four deaths; one cesarean section, death on the tenth day; one cyst of the kidney, weighing seventy-four pounds, died of exhaustion; one fatal case of extra-uterine pregnancy, operated on six weeks after rupture, general peritonitis with pulse 130, temperature  $103^{\circ}$  for the week previous; one fatal case of general abdominal cancer, three exploratory incisions, all recovered. Total, seventy-two laparotomies, with fifty-nine recoveries and thirteen deaths.

Of the fifty-eight ovarian operations, the first three deaths were the second and third and fifth of his series. In the last fifty-two ovarian operations there have been only two deaths, one of these was from tetanus occurring on the fifteenth day after operation, when every thing indicated a perfect recovery. The other was an insane patient who had been four years in an insane asylum on account of nymphomania. She could not be entirely controlled, and her efforts to get out of bed set up inflammation about the abdominal sutures, causing an abscess, which burst internally and caused death.

Dr. Johnson emphasized the statement that experience in operating was nowhere so valuable as in the abdominal cavity; that the "unexpected" was so often found that many cases would be lost if the operator was not prepared for and equal to the emergencies as they "unexpectedly" arose.

The following papers were read by title:

1. Puerperal Eclampsia, by John Herbert Claiborne, Petersburg, Va.

2. Laparotomy in Intestinal Obstruction,

by Cornelius Kollock, A. M., M. D., Cheraw, South Carolina.

3. The Causes of Frequent Failure of Relief of Reflex Symptoms after Trachelorraphy. by W. F. Hyer, M. D., Meridian, Miss.

The following officers were elected:

President, Dr. George Engelmann, of St. Louis, Mo.; First Vice-President, Dr. B. E. Hadra, Galveston, Tex.; Second Vice-President, Dr. Duncan Eve, of Nashville, Tenn.; Secretary, Dr. W. E. B. Davis, of Birmingham, Ala.; Treasurer, Dr. Hardin P. Cochran, of Birmingham, Ala.

On motion the Association adjourned to meet in Atlanta, Ga., on the second Tuesday in November, 1890.

#### MCDOWELL MEDICAL SOCIETY.

Twenty-ninth Semi-annual Meeting, held at Henderson, Ky., November 11, 1889.

The Society was called to order at 10 A. M. by the president, Dr. John E. Pendleton, of Hartford, Ky.

Dr. Ap Morgan Vance, of Louisville, read a paper on Anti-septic Surgery, in which he said the great progress of surgery in the past ten years has been just in proportion to the increased understanding and confidence in the power of antiseptic and aseptic methods of wound-treatment. The day is not far distant when a man will be ashamed to admit the formation of pus in a wound of his making. He is now ashamed of such a result, as he knows that it is by some neglect on his part that it is there. The technique, he said, is to be acquired by reading the medical journals of the day, and making trials of the methods there described.

Dr. Vance then, by a series of *don'ts*, directed the attention of the members to the importance of the little things in this kind of work, reporting cases illustrative of the results to be obtained.

*Don't* fail, when possible, to have a general bath before doing a major operation.

*Don't* do any operation with suspicious hands; hot water, soap, nail-brush, and penknife should be carefully used by the principal and

assistants before any operation. It is best to cut the nails very short, so there will be no place for germs to lodge in.

*Don't*, just before or during the operation, put your fingers about your nose, eyes, or ears, or use your handkerchief, or shake hands with any one. It is better even to offend a visitor than to run the risk of infection.

*Don't* pick up or allow your assistants to touch any instrument, sponge, or suture that has fallen upon the floor during the operation.

*Don't* bite off the end of a suture that it may the more easily be threaded.

*Don't* put your knife or other instrument in your mouth or behind your ear preparatory to its use.

*Don't* fail to detail some one to wipe your face during a long and laborious operation.

*Don't* cough or sneeze over the operative field; consequently the use of tobacco or the presence of a cuspidor should be forbidden in the operating-room.

*Don't* fail, when possible, to have the patient bathed and clothing changed before an operation. When this is not possible, thoroughly cleanse the field, and never make or dress a wound where the surrounding parts have not been shaved thoroughly.

*Don't* allow any visitor to handle the field of operation after the patient is prepared, unless he is aseptic.

*Don't* allow visitors who are doubtful, that is, who are attending patients with gangrene, erysipelas, or puerperal fever, etc., unless they have taken all precautions.

*Don't* fail to have the field surrounded by warm sublimated towels.

Discussion by Drs. G. Frank Lydston, of Chicago, A. M. Owen, of Evansville, Ind., I. N. Love, of St. Louis, J. Y. Brown, of Henderson, Ky., and discussion closed by Dr. Vance.

Dr. I. N. Love made some remarks on the Management of Fevers. He said in nearly all the cases of fever which came under our observation, after it is well established that they are continued fevers in matter what the cause, the management of them rather than the medication is what we wish to obtain, yet there are times when medication is an important part of

the management. The latter should be secondary, however. When called to a case of fever we find a high temperature, with a history invariably of chill. In malarial fevers we have a history of days of discomfort, headache, bad digestion, etc., with no well-defined chill or rigor. In fever cases the first thing is to clear out the sewers of the patient, keeping open the secretory and excretory organs, by giving good doses of calomel along with compound jalap powder, followed by some saline purgative. Sometimes thorough cleansing of itself overcomes the fever; then proper measures should be taken to prevent its recurrence. The alimentary canal having been cleared out, management rather than medication should be employed.

The ice-water given patients should be boiled and kept hermetically sealed in an ice-chest; so too with the milk given fever patients. Cleansing the mouth and teeth are important factors. No patient with typhoid fever should have sordes on the teeth. An item of vital importance is tranquility of both mind and body. Friends should not be permitted to see fever patients. The physician should insist upon the patient using a bed-pan, saving as much muscular effort as possible. With a view to producing this tranquility the administration of medicines which produce sleep are of great value. Sleep is one of the most curative agents in fevers. In controlling temperature the speaker highly recommends acetanilid. He has used it in a large number of cases with very satisfactory results. Given in doses of  $2\frac{1}{2}$  grains every two to four hours to an adult, it reduces temperature at least one and a half degree, and keeps it down. The speaker gives it in the form of a solution with brandy or Tokay wine, which makes an ideal stimulant. He also alternates the sponge bath with the administration of acetanilid.

The hydro-therapeutic treatment of fevers had received considerable attention of late, and among the more interesting articles that have been written are those by Drs. Barach, of New York, and G. C. Smythe, of Indiana.

Quinine, as an antiperiodic, should be ruled out; yet if there is a malarial element it was the remedy to determine it. Quinine disturbs

the nervous system, demoralizes the alimentary canal, and impairs digestion and nutrition.

Dr. Love, in closing, favored the pre-digestion of all foods for fever patients for various and obvious reasons, which he gave at considerable length. The author has found bovine to be very satisfactory in such cases; it is well received, well retained, and is unquestionably very nourishing.

Discussed by Drs. P. Thompson, of Henderson, Ky., W. C. Cook, of Henderson, Ky., W. C. Smythe, of Henderson, Ky., C. Frank Lydston, of Chicago, A. H. Owen, of Evansville, Ind., Bransford Lewis, of St. Louis, Mo., and discussion closed by Dr. Love.

Dr. J. E. Pendleton, of Hartford, Ky., read a paper on Trephining, with Reports of Cases. He said trephining within itself is not a dangerous operation. There has not been a record of cases in which all other factors of danger have been eliminated. The operation is done for the relief of some injury or other pathological condition which either impairs the health or imperils the life of the patient.

Operations done for the relief of epilepsy are more nearly fair examples from which to calculate the mortality rate than any other class of cases that have been recorded. Even in these, if the epileptic seizures be due to old traumatism of the skull, with spiculæ of bone or exostoses impinging upon the brain or its membranes, they should be excluded. It has not been the speaker's fortune to be called to use the trephine for tumors or epilepsy. His experience with the instrument has been for the most part confined to recent traumatic injuries of the head. In two of the cases he had treated exostosis of the inner table was found. He reported five cases upon which he had successfully operated, and four in which the indications for trephining were palpable.

He concluded by saying that, much as had been learned and published within the last two decades with regard to the functions of the cerebral centers, we are not yet in possession of sufficient knowledge to shield us from the danger of making mistakes in locating cerebral lesions. The very complex anatomical arrangement of the nervous centers and their connecting tracts, the facts that two or more areas

may be intimately connected with the same function, and that lesions of the same location in different individuals may not produce like definite results, conspire to hinder correct diagnosis. Tumors and abscesses embedded deeply in the brain substance, that would inevitably have terminated life, have been extirpated or evacuated and the patients restored to health. Perilous as may seem these daring ventures in brain surgery, the speaker said, there will be found many whose lives have been made so miserable by constantly recurring fits of epilepsy, and failed of relief in other directions, who will gladly avail themselves of almost any operation to get rid of their malady. In depressed fractures, in sub-dural or sub-cranial hemorrhage, or in traumatic abscess, if the local symptoms are of a reliable character, there should be no hesitation about operating.

Judging from his own observation and all the information he had gathered concerning the conditions of the skull and brain for which trephining may be done, he could only say that the propriety of operating depends mostly upon our ability to make a correct diagnosis.

Discussed by Drs. Vance, Owen, Lydston, and discussion closed by Dr. Pendleton.

Dr. E. H. Luckett, of Owensboro, Ky., read a paper on *The Relations of Mothers in Nursing their Children*. He said: In investigating the operation of natural laws we can not fail to observe the mutual relationship and reactions which they produce in their fulfillment, and this relationship holds good whether they are acting rationally or aberrantly. In no field of their operation is this to be more observed than in the laws regulating biological processes or pathological divergencies. Each law, as it applies itself to the development of functional activity in this or that organ, is aided by its relationship. In but few organs is this law more beneficently displayed than in the milk glands and the uterus, where the one has for months been caring for and growing a loving being, and the other developing for the care of the infant in its independent existence. To ruthlessly set this order at defiance is to invite serious disaster to the woman and greater perils to the child. There is no condition of humanity more to be deplored than that arising

from the pathological conditions following childbirth, and among the many causes for these disturbances failure to nurse stands out boldly and forebodingly. That every mother should nurse her child, except for want of milk or grave disease, will not be gainsaid. It is the demand made by the laws of her condition, and she can not shirk the task or transfer the responsibility without inviting injurious results to herself and taking large chances for physical and mental defects to her child, entailing upon it a puny existence, and too frequently an early death. Nature intended that woman should nurse her children, and consequently that pregnancy and child-bearing should not occur oftener than the normal condition permitted, amounting to one child-bearing period in each eighteen months or two years. But with the dry woman this occurred in from ten to fifteen months, subjecting her to all the mental anxieties, all the nerve perturbations, both reflex and direct, and all the functional derangements incident to this period almost continually during the life of her fecundity.

Another condition arising much more frequently in the nursing woman is abortion. This is, no doubt, to a great extent the result of the frequent pregnancies which woman are subjected to. These abortions are one of the most fruitful causes of local pelvic troubles, both acute and chronic, and add largely to the list of penalties which women pay for neglect of duty in discarding the motherly care of their offspring.

Discussed by Drs. Hanna, of Henderson, Ky., Love, Owen, Lydston.

Dr. Bransford Lewis, of St. Louis, Mo., read a paper on *The Treatment of Gonorrhea by the Ointment Method*, in which he deprecated the use, in the early stages of gonorrhea, of astringents, caustics, or other means, antiseptic or otherwise, which would tend in any way to increase the irritation already present, giving as his reason that, aside from the injurious effects which they might produce on that account, they were inefficacious in reaching or killing the gonococci, the morbid agents, because of the behavior of the latter with reference to the tissues in which they dwell. Admitting the inability to cut short a specific

gonorrhea in a few days or a week, he had advised a plan of treatment having for its object the conduction of the disease through its several stages as quickly, as pleasantly, and as safely as possible; and nothing appeared to him to be more liable to attain these ends than the introduction of a bland ointment, medicated as desired. It is soothing to the inflamed membrane; it keeps the opposing surfaces from rubbing against one another, and in this way obviates all auto-irritation. It affords a continuous application of any medication, without giving rise to any additional trouble to the physician or annoyance to the patient.

Dr. Lewis then exhibited the instrument or applicator which he uses, and described it in the following language: "This instrument is simply a hard rubber ointment box, fitted at one end with a screw-piston for pressing the ointment out the other end into the soft rubber catheter attached thereto. The catheter, having three holes at its end, is a No. 2 French, small enough, smooth enough, and flexible enough to glide for a half inch or so into the most sensitive urethra, generally before the patient knows that it is in. The ointment is then squeezed out, pressure being maintained all the while around the glans, so that it is compelled to pass backward over the inflamed area. The catheter is then withdrawn, and a muslin hood, lined with clean, non-absorbent cotton, is placed over the penis and retains the application until the next urination."

Lately he had been using albolene, an ointment base which is such an inert and indolent substance that it neither changes nor becomes rancid with keeping or in combination with medicines. It is odorless and almost tasteless. He prefers it to lanolin because of the qualities mentioned, and is now using it exclusively and with perfect satisfaction.

Discussed at length by Drs. Lydston, Brown, Vance, and closed by essayist.

Dr. William Cheatham, of Louisville, Kentucky, read a paper entitled Phlyctenular or Scrofulous Ophthalmia. He said the management of these cases is quite simple in a great majority of them, but we occasionally come across cases where the cornea may be per-

forated, or one in which we have frequent relapses, which puts the physician to no end of trouble and of worry. In these cases the hygienic management and the constitutional treatment are of extreme importance; in fact, the most frequent cause of this affection is bad hygiene. As to feeding, all sweets should be cut off, likewise tea and coffee. Fresh meat should, if possible, be given twice a day; none for supper. Limit the patient to good, nutritious food. Patient should be kept out of doors as much as possible. The local treatment in phlyctenular conjunctivitis is cleanliness, with hot or cold carbolized water, as the patient prefers. Atropia sulph. grs. ij, aqua dest. 3j, to be dropped into the eye three or four times a day if the inflammation is severe or if there is any photophobia. If dry calomel can be dusted into the eye about noon each day with a camel's-hair brush, it should be done, or the calomel may be mixed with pulverized white sugar, half and half.

Discussed at length by Dr. J. M. Ray, of Louisville, Kentucky.

Dr. P. Thompson, of Henderson, made some oral remarks on The Hygienic Management of the New-born.

Dr. G. Frank Lydston, of Chicago, read a paper on The Evolution of the Local Venereal Diseases, in which he said, that following the period of confusion regarding venereal diseases which existed up to the advent of Ricord and his school came the belief that gonorrhea was a specific entity and not identical with syphilis. Bassero, a pupil of Ricord's, taught that chancreoid and chancre were each specific entities, and this view is the most generally accepted one at the present day. There has arisen, however, in recent years a few heretics, who, while assuming that syphilis is a specific entity, hold different views regarding chancreoid and gonorrhea. Personally, he was convinced that chancreoid and gonorrhea are diseases which may arise *de novo*, and which are in the true sense of the term not specific. It is only by an acceptance of this theory that it is possible to understand something of the origin of these diseases. It may not be possible to demonstrate the origin of all infectious diseases, but it is incomprehensible

that a "specific" poison has always existed in any instance. Through the germ theory we apparently see a little light regarding the origin of infectious diseases. Diseases are incident to the life of every animal, and as we study the evolution of the animal so should we study the evolution of its diseases. Diseased germs are the natural enemy of man. He has been able to contend successfully with all other adverse elements, but not with those little organisms, the germs of disease.

He believed that the local venereal diseases are the result of the propagation and differentiation of germs primarily innocuous. The innocent germs of the atmosphere may multiply in a favorable environment, and the result of such multiplication finally become through successive cultures virulent. Filth, heat, moisture, and protection from air and light favored such changes. Thus the descendants of innocuous germs may have properties which are virulent, dependant upon the environment in which they are developed. Thus we may have by a process of evolution an apparently spontaneous development of diseased germs. In the higher degrees of cultivation the germ would necessarily acquire properties by virtue of which it would almost invariably produce so-called specific results.

The effects of the germ, even after it enters the tissues of the human being, vary according to (1) its virulency and vitality, (2) the inherent vitality of the individual affected, (3) idiosyncrasy, (4) activity of elimination, (5) the condition of the tissues, (6) the number of germs and length of time of exposure.

The experiments of Pasteur on chicken cholera show conclusively what may be done in the way of modifying germs by proper culture. Is it unreasonable to suppose that such cultivation may occur in nature's laboratory? As a consequence of the wide-spread variation in the circumstances controlling the development of germs in the female vagina, the essayist believes that there may result from different inoculations of essentially the same products of evolution different degrees of infection. Thus the disease acquired by exposure

to materials may be, (a) Simple balanitis, balanoposthitis or venereal vegetations; (b) simple urethritis; (c) virulent urethritis; (d) simple venereal ulcer indistinguishable from advanced herpes, and (e) classical chancre.

Discussed at length by Dr. Lewis.

The Society then adjourned.

## Reviews and Bibliography.

Chemistry: General, Medical, and Pharmaceutical, including The Chemistry of the United States Pharmacopœia. A Manual on the General Principles of the Science and their Applications in Medicine and Pharmacy. By John Attfield, F. R. S., M. A., and Ph. D. of the University of Tübingen, etc. Twelfth edition. Philadelphia: Lea Brothers & Co. 1889.

Physician's Pocket Reference Book and Visiting List for 1890. J. H. Chambers & Co., publishers, St. Louis, Mo. *Contents:* Calendar; Prediction of Date of Confinement; Artificial Respiration; Care of Galvanic Batteries; Disinfectants; Clinical Examinations of Urine; Poisons and Antidotes; Table of Doses; blank leaves for weekly call list, and various memoranda. The matter is well selected, and well arranged. The price, 75 cents, is certainly very low.

The Physician's Visiting List (Lindsay & Blakiston's) for 1890. Thirty-ninth year of its publication. In one or two volumes. Price, \$1.00 to \$3.00, according to the space required for daily or weekly registry of patients. P. Blakiston, Son & Co., Philadelphia. This oldest and best known of the visiting lists comes with the new year unchanged in form, and with such alterations in contents only as were called for by recent therapeutic advance. In compactness, neatness, and completeness it is a marvel.

A Hand Book of Pathological Anatomy and Histology, with an Introductory Section on Post-Mortem Examinations and the Methods of Preserving and Examining Diseased Tissues. By Francis Deland, M. D., Professor of Pathology and Practical Medicine, College of Physicians and Surgeons, New York, and T. Mitchell Prudden, M. D., Director of the Laboratory of the Alumni Association of the College of Physicians and Surgeons, New York. Third edition. Illustrated by two hundred and twenty-four wood engravings. Printed in black and colors. New York: William Wood & Co. 1889.

## Correspondence.

### PARIS LETTER.

[FROM OUR SPECIAL CORRESPONDENT.]

In a work just published by Prof. Jules Rouvier, of the French Faculty of Medicine at Beyrout, Syria, the author treated of impaludism in suckling women. The question of the infection of a healthy nursling by the milk of its nurse affected with impaludism has always been very much controverted. Admitted by some eminent physicians, this opinion has been combated by physicians equally eminent. In these conditions Dr. Rouvier gives us the fruit of his clinical experience. The multiple examples of malaria during nursing which he observed in Syria, since 1883, are arranged in three distinct groups. The paludal infection affects: (1) The nurse alone. (2) The nurse and her nursling. (3) The nursling alone. By this methodical division the learned professor demonstrates the non-transmission of impaludism by the milk of nurses. He, however, points out the inconveniences, and deduces practical conclusions which may be summed up in this therapeutical axiom: The alkaloid of the cinchona should be administered under the form of hypodermic injections. While denying the transmission of malaria by the nurse's milk, Dr. Rouvier does not hesitate to affirm that the parasitic origin of intermittent fever may be considered a fact. Whatever be the real form and nature of the pathogenic microbe, this micro-organism exists in the blood; but on the other hand observation has demonstrated that at all ages of life malaria is contracted only through the respiratory passage. The author sums up by the following conclusions: In cases of paludal infection occurring simultaneously in the nurse and her nursling, the nurse must be changed. In the case where the latter alone is affected, one must be cautious in having recourse to quininized milk by administering quinine to a healthy nurse. The quininoidical therapeutic should be applied directly to the child, but as the stomach in the child is not suitable to facilitate the ab-

sorption of the medicamentous principle, the latter should be administered under the hypodermic form. In similar cases in Corsica, as in Algiers and marshy Tuscany, Dr. Rouvier states that he always had recourse to repeated frictions under the arm and in the inguinal region, with an ointment composed of five grams of the sulphate of quinine in thirty grams of axunge.

In his thesis for the doctorate Dr. Lasserre selected for his subject *The Treatment of Chronic Adenitis and of Cold Abscesses by Injections of Naphthol*. In this thesis the author points out the following inconveniences due to the treatment of iodoformed ether: (1) Violent pain due to the sudden distension which follows the injection. This distension has sometimes produced extensive sphacelus of the skin or compression of the neighboring organs. (2) Cures very slow, as a great interval should be allowed between two successive injections, and at least three or four should be practiced. (3) The danger of the ether producing prolonged sleep, difficult to overcome. Moreover, iodoform in an anfractuous cavity offers dangers of iodoformic poisoning. Naphthol is inoffensive, very antiseptic, but little soluble. It is soluble in water in proportion of one gram to the liter with the addition of fifty grams of alcohol. For injections of naphthol the author recommends the following solution, the formula of which was given by Prof. Bouchard: Naphthol B. 5 grams, alcohol 33 grams, hot distilled water *q. s.* for 100 centigrams, the whole to be filtered while warm. At the moment of employing the injection the phial should be plunged into hot water. At the same time the syringe should be bathed in a hot antiseptic solution. These precautions are necessary to prevent the precipitation of the naphthol, which would block up the needle or the canula of the trocar. After the evacuation of the pus the injection of the antiseptic solution should be practiced slowly.

In the treatment of orchitis Dr. Dupau, of Toulouse, recommends the application of a layer of iodized cotton on the scrotum, which is to be maintained in position by the aid of

a suspensory bandage which will at the same time exercise a certain degree of pressure. He observed, in a great number of cases in which he employed this method, that the painful phenomena of orchitis completely yielded at the end of from eight to twelve hours of treatment. The entire cure was obtained on an average of from three to eight days, and the induration of the epididymis, which often persists for a long time, had disappeared at the end of from fifteen to eighteen days. The author remarks that this treatment doubtless acts by compression, but it is also natural to admit that the slight revulsion produced on the scrotum should be taken into account, as also the eminently resolving properties of the iodine.

In the treatment of hydrocele Dr. Polailon no longer employs the time-honored injections of the tincture of iodine. He substitutes a one-tenth solution of the chloride of zinc, and thus prevents the pain caused by the tincture of iodine. He was aware that cocaine was used to deaden the pain; but Dr. Abadie stated, at a late meeting of the Academy of Medicine, that he knew of an instance of death resulting from irrigation of four centigrams of cocaine during an operation for ectropion. The patient, a woman, had previously exhibited cerebral hemorrhage. She was operated on at 3 o'clock, and died at 8 o'clock, probably from a second attack of cerebral hemorrhage. Dr. Polaillon observed that, as cocaine is dangerous and iodine painful, it is best to use the chloride of zinc.

At a recent meeting of the Société Médicale des Hôpitaux Dr. Doyon read an interesting note concerning the accumulation of the bromide of potassium in the system—an epileptic patient who had been treated by the bromide of potassium in large doses. Before death he was continually somnolent. The liver and brain were removed from the body and analyzed. They were calcined and then treated with nitrate of silver; the bromide of potassium present was thus changed into bromide of silver. It was ascertained that the brain contained 1.934 grams of the bromide of potassium, and the liver 0.73 grams. Dr. Doyon does not consider that this case should pre-

vent medical men giving small doses of the bromide of potassium. Careful clinical observation of patients treated by the bromide of potassium showed this substance to be very slightly toxic. The author has also made experiments on animals, which prove that large doses of the bromide of potassium can be administered for a considerable time without injuring the health.

PARIS, November, 1889

## Abstracts and Selections.

**OSTEO-ARTHRITIS AS AN IMMEDIATE SEQUEL OF RHEUMATIC PYREXIA.**—Clinical observation has established a pathological connection of great practical interest. It has been long known that chronic rheumatism and gout may prepare the way for osteo-arthritis by lowering the textural force of the joint structures, and thus leading to morbid change of a degenerative kind. In people of the so called tubercular diathesis, or who have near kinsfolk distinctly "consumptive," repeated rheumatic attacks may beget a condition commonly called *rheumatoidal*; and this, again, may gradually pass into the more complete and incurable state which enjoys the official title of osteo-arthritis.

This clinical doctrine being fully recognized, the precise point of this paper may be formulated as follows: A man or woman in early middle life has two or three attacks of acute rheumatism close together, affecting (perhaps) knees, elbows, or wrists; he is more or less in bed for several months; the pyrexia is rarely higher than subacute; and there are periods of quiescence during which he not only feels comparatively well, but really acts well in the sense of "muddling about," somewhat crippled it may be, but with a convalescent energy deserving praise. Nevertheless, the patient does not wholly emerge from a quasi-rheumatic condition. And it is of such sufferers that we constantly ask ourselves, especially in our Mineral Water Hospital, *is this case gone off rheumatoidally*; is he marching in the direction of osteo-arthritis? An exceedingly practical question. Two groups of clinical phenomena appear to coalesce; the latter looks a mere postscript of the former, continuous in time and quality; in reality it is so different that the treatment calculated to moderate the one may only increase the other. The pyrexia is gone, but the pulse remains quick, or even quicker; the true rheumatic sweating has passed away, but a new type of sweating begins; and we are conscious of a fresh series of clinical phe-

nomena, some of which are a mere continuation of the old (such as pain and enfeeblement of joints), and others are the commencement of an entirely different order of symptoms.

Now our plea at the outset of this discussion is, that what has been described as acute rheumatoid arthritis has no clinical existence. The state of things so denominated is merely a rheumatic prodroma of rheumatoid arthritis, preparing the way and leading on to it in subjects predisposed. There is no such predisposition in the vast majority of cases; rheumatic pyrexia comes and goes, leaving perhaps some traces of medical damage, which is usually quite remediable.\* But, after coming and going two or three times, the true rheumatism may become something else, not merely something chronic in the room of something acute, but a slow grade of an essentially different arthritic trouble, the steps of sequence to it being caught only by a practiced eye. So far as joints are concerned the transition is probably not marked at all; what was swollen and painful remains swollen and painful; the objective lesson is not easy to read. But we pick up the threads of diagnosis by studying the concurrent facts. The pyrexia is slight, and obeys other laws; pigmentary stains and spots appear, and the neural signs of pain and muscular atrophy possess a new significance. The weakness and incapability of movement increase quickly. In doubtful cases the dynamometer should be always used; little impression is made upon it by the palsy-stricken muscles of the hands. But it must be confessed that, through inattention or lack of insight, the clinical condition of the patient may undergo an entire change without a single note being made of it by any one.

The therapeutic issue of these considerations is of the highest moment. When the true rheumatic storm has subsided, it is not only injudicious but very hurtful to go on prescribing salicin and the salicylate salts, and potash or soda in any guise. The iodides are equally useless, and perhaps equally injurious. Salicin is bound up with rheumatism by the closest ties; it is one of the magnificent advances of recent years; and so it follows that any arthritic affection which looks like rheumatism suggests a salicin treatment. Or, if a distinct gout has preceded the osteo-arthritis, the chance is that colchicum and alkalies are continued. The case is now called "suppressed gout," or "latent gout," or any other dark veil of words which are algebraic signs of what we do not understand. The physician who is

blind to what is going on before him had far better leave his patient alone. I can not speak too strongly of the mischief done by this wrong system of medicine. The drugs thus wrongly given are not those "phantom" drugs, idle for good or harm, but agents of positive evil. They lower the nerve tone and impoverish the blood quality; and, worst of all, they occupy that precious time during which the ingravescent osteo-arthritis should be fought with its proper weapons. When the mistake is found out, the sad legend "too late" has to be written. The unhappy patient is a life-long mourner of an irrevocable fate; and the doctor who errs from want of experience has leisure to think over an imperfect diagnosis.

To grasp the point of time when one pathological current stops and another begins is to hold the key of the position. We push aside the so-called specific remedies; we tranquilize the nervous and vaso-motor systems by quinine, belladonna, and strychnine; as soon as possible cod-liver oil and arsenic are brought to bear, to be followed at no long interval by a stable preparation of iron. There must be corresponding changes in the diet, which ought to be rich in nitrogenous and fatty material. And if we have been so unwise as to order alcohol under the poisonous garb of brandy or whisky, we shall now recommend a moderate amount of generous wine, at least four ounces daily of dry old port or of matured burgundy.

And now comes the hygienic and therapeutic touch of the Bath thermal waters. Let them be used with every care. I am obliged to admit that hydro-therapeutics and shampooing are sometimes overdone. The delicate atrophied creatures who submit to these processes require to have them performed in the gentle manner of reclining baths, quiet douches, and domestic massage. Most good is to be expected from our thermal waters when there is an antecedent history of rheumatism or of gout. In other cases, when osteo-arthritis is distinctly a sign of local or general deterioration, internal medicinal treatment is of at least equal value. One more caution. So-called counter-irritation (with iodine, for example) should never be done immediately over an affected joint. Such a process is essentially unscientific, for it creates an artificial excitement and hyperemia in the very structures which we should try to keep in a quiescent mood.

The accumulation of clinical material at our thermal Spa affords a splendid school of study in osteo-arthritis. The subject is complex, with many by-paths reaching among the thickets of physiological pathology. A complete scheme of the neurology of osteo-arthritis has yet to be unfolded. The arthritic disease,

\*The term chronic rheumatic arthritis should be strictly confined to the arthritic lesions produced by true rheumatism; the confusion of our terminology has caused confusion of ideas.

paradoxical as it sounds, may not be the central lesion at all; it may be only one member of a group of lesions, and not the most important. The writings of Sir Dyce Duckworth and Dr. Ord have contributed much to the solution of our difficulties; and rays of light are coming from many other quarters.—*Dr. J. K. Spender, London Lancet.*

**MORPHOLOGY AND PATHOLOGY OF NERVE TERMINATIONS IN MUSCLE.**—Before the Paris Academy of Sciences, October 7th, Messrs. Babes and Marinesco reported their studies and experiments in the direction above indicated. The following is a brief *résumé*:

A modification of histological technique has enabled them to enter into an extensive consideration of nerve terminations in muscle. In examining a terminal plaque of the lizard with a strong apochromatic homogeneous immersion lens they observed two substances in the last segment of the axis cylinder. One is darkly and strongly colored by gold, and stretches out in a network; the other, paler, of a fundamental character, seems associated with the pale substance of the plaque. The sheath of Schwann, spreading out, covers the plaque and becomes continuous with the sarcolemma. In the plaque the dark substance forms many sinuous ramifications communicating in arcades and possessing lateral branches terminating in crosses. In this substance exist many small rounded nuclei. It appears that the dark substance is continued throughout the plaque by the paler material which surrounds it. In the normal state fine lateral branches of the dark substance are rarely seen entering distant nuclei of the sarcolemma, while certain fine prolongations of the periphery of the fundamental material enter the intimate structure of the muscle. In man the structure of the plaque is comparatively simpler.

By cutting the sciatic nerve of the lizard we have determined an excessive atrophy of the muscle nerves and of the plaques, a breaking up of the network of dark substance, and a disappearance of the nuclei. We have repeated these experiments upon the rabbit on a very wide scale. Thirty-six hours after section of the sciatic nerve the lesion is more pronounced in the terminations than in the small peripheral muscle nerves. It consists of a nearly total disappearance of the dark network. In place of the ramifications dark pyriform cells are seen. The fundamental pale substance and the fundamental nuclei are quite visible. These nuclei are rounded, increased in number, usually rounded, and have a fine granular zone about them.

Most of the lesions found in maladies of the

nervous and muscular systems correspond in general with the lesions experimentally produced. Thus, in simple muscular atrophy an atrophy of the plaques is found, sometimes with proliferation of the nuclei. In hypertrophy of certain muscles and in Tomsen's disease there is uniform hyperplasia of the dark substance. In typhoid fever there is found a simplification of the terminal plaque, and often the peripheral portion of the terminal fiber is replaced by a very fine filament. In the pseudo-hypertrophy of adults we have noticed a disappearance of the dark portion not only of the plaque, but often also of the terminal interannular segments. At the same time there often exists a proliferation of the fundamental nuclei. In a case of lateral amyotrophic sclerosis the terminal fibers and the plaques were extensively atrophied. In the multiple neuritis of Leyden we have in general determined the existence of the same conditions, but at the same time the signs of a new formation are seen, and sometimes even a proliferation of the nuclei of the plaque. —*Semina Médica, Journal American Medical Association.*

**EFFECT UPON THE HUMAN BODY OF A DIET CONSISTING ENTIRELY OF LEAN MEAT AND WATER.**—Can life and health be sustained indefinitely upon a diet of lean meat and water without any farinaceous food at all? Physiologists tell us that it can not; experience seems to negative their assertion. It is highly desirable that this question should be cleared up and finally set at rest, both from a practical and from a purely scientific point of view. A diet of lean meat is now being advocated for several purposes in practical medicine, and it is of the highest importance that we should know for certain for what period it can be carried on without injury to the patient. In this country it is being used chiefly for the reduction of obesity, but in New York Dr. Salisbury and several other physicians are making an extensive use of a diet consisting entirely of lean meat and water, not only for that purpose, but also in the treatment of dyspepsia, phthisis, ectasia of the stomach, and in the absorption of new growths. In the latter case Dr. Salisbury claims that by increasing the metabolism of the body recently formed tumors can be absorbed. In order to procure these results, he and his followers continue the use of a diet consisting entirely of lean meat and water for a period of at least several months, and, they state, not only with perfect impunity, but with absolute benefit to the general health of the patient.

Let us now turn to Landois and Stirling, which we may accept as one of the most recent

standard text-books on physiology, and see what they say upon the subject. On page 482: "To obtain the 448 grams of carbo-hydrates necessary to support him, a man must eat 2,261 grams of beef." Again, on page 485: "A man is not able to maintain his metabolism in equilibrium on a purely flesh diet; if he were compelled to live on such a diet, he would succumb. . . . If a man is to obtain 280 grams C. from a flesh diet, he must consume, digest, and assimilate more than two kilos in twenty-four hours. But our digestive organs are unequal to this task for any length of time." The reason why I am bringing this subject before the notice of the profession is that there are now being exhibited at the Westminster Aquarium a family of savages who have lived all their lives on nothing except lean meat, fish, and water, without succumbing, as we are told they ought to have done. Those interested in the physiology of diet have now an opportunity which they have never had before in this country of investigating a purely carnivorous man.

They are a family of cannibals from Terra del Fuego, belong to the tribe of Onas, and consist of five adults and two children. The adult male is thirty years of age, of normal weight and development, takes little or no exercise, and eats every twenty-four hours five pounds and eight ounces of lean cold boiled horseflesh, two pounds of raw fish, and one or two eggs, and drinks about four pints of water at the most, probably rather less. As near as can be ascertained, he passes about the normal quantity of urine in the twenty-four hours, and a sample passed about three hour after his last meal at night yielded the following results on examination. Sp. gr. 1020; faintly acid, no albumen, no sugar, an excess of phosphates, but urea fifteen grains to the ounce, and uric acid one sixth of a grain per ounce only!

A careful study of the case presents to us the following facts for our consideration: (1) It is generally admitted that the inhabitants of cold climates must eat more fat and farinaceous food than those of warmer parts. Now in the island where these people come from there is nearly always snow on the ground, and notwithstanding that they reject fat from their diet, and take no starchy food at all. (2) It is generally believed that the only conditions under which a diet of meat can be indulged in with impunity is when it is accompanied with a large amount of exercise, and the ingestion of a considerable quantity of water. Now these people do not drink anything like an excess of water, and they take hardly any exercise at all. They spend most of their time in sleep. It would be an interesting point to determine whether their drowsiness might not possibly be due to auto-intoxication from leu-

comaines developed during digestion. (3) This case entirely disposes of the allegations of those philosophic traditionalists who affirm that excess of meat in the food produces uric acid and gout. Among these meat-eaters gout is unknown. Dr. Mortimer Granville, almost alone, I believe, of modern physicians, has always maintained that excess of meat does not do so. I find in his recent work (*Gout in its Clinical Aspects*, page 10), the following: "It is on these hypotheses mainly that the prevailing method of treating gout by limitation of flesh food is founded (that is, that urea and uric acid as they appear in human urine are to be regarded as serial or progressive products of the dissimilation of the nitrogenous elements of the food). It is inexplicable to me that this policy should find favor with physicians who base their treatment of disease on physiological principles, seeing that there are good reasons for believing that much more depends on the changes that take place in the elements of the food after digestion than upon their form when consumed." (4) Finally, I would suggest that the consideration of this remarkable tribe of people inevitably forces us to one of two conclusions, either that the generally received opinions on the subject of diet as contained in works on physiology are unreliable and should be revised; or that it is possible so to alter the metabolic mechanism of the body by hereditary influence as to enable the individual to exist in defiance of all the ordinary physiological laws of nature.—*London Lancet*.

INTERNAL URETHROTOMY IN CUBA.—Dr. Ignacio G. Plasencia, in his inaugural communication on the occasion of his admission to the Cuban Royal Academy of Medical, Physical, and Natural Sciences, gives an account of one hundred and thirty-three cases in which he has performed internal urethrotomy. The conclusion to which practical experience as surgeon to the Mercedes and Paula hospitals leads him, as compared with what he had previously seen in European clinics, is that strictures treated by cutting from within do particularly well in Cuba, a good deal better than in Europe, the climate appearing to favor this operation in a remarkable manner, urethral fever being much less frequent, and, when present, less severe, than is usually found to be the case after urethrotomy in Europe. None of his cases were complicated by purulent infection, and extravasation of urine occurred in five only of the oldest and tightest strictures, which were not operated on as soon as they ought to have been. The instrument preferred by Dr. Plasencia is that of Maisonneuve. Four cases died, but some time after the operation, and apparently not in consequence of it.—*London Lancet*.

# The American Practitioner and News

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## AGAINST MEDDLESOME MIDWIFERY.

In the Boston Medical and Surgical Journal of the 5th inst. is a report of one hundred and eighty-seven cases of midwifery which the would-be progressive obstetrician might do well to contemplate. The author is Dr. Marie E. Zakrzewska, of Boston, for many years *accoucheuse-en-chef* of the Royal Charité of Berlin. This lady takes a tilt at nearly every thing in the line of so-called obstetric improvement, insisting that in all uncomplicated cases, from the first premonitory pain to the passage of the placenta into the vagina, the delivery should be left to nature. And she seems to prove her faith by her works, for after denouncing almost every measure for facilitating labor, from ergot to placental expression, she proceeds to report one hundred and eighty-seven consecutive cases of midwifery in private practice wherein no woman was lost and no children sacrificed; the children dead being those only who succumbed before labor came on or who were born prematurely. Furthermore, there were no cases of childbed fever or peritonitis in the list, nor any ruptured perineums or cases of subsequent cellulitis reported. Convulsions were encountered in three cases, but after delivery, and they

were without serious consequences. But one case of serious hemorrhage appears in the list. The forceps were used but seven times out of the one hundred and eighty-seven, and the death of two children is charged to their account. The placenta came away unassisted in one hundred and seventy-three cases; "in ten cases a partially loosening placenta, requiring introduction of the hand and artificial removal on account of hemorrhage; in three cases there were completely adhered placentas, requiring forcible removal after waiting two hours or more; only one case of placenta prævia (partial) occurred." In six cases the labor lasted more than forty hours, the majority of the women being delivered in from ten to twenty hours. Of the prolonged labors there was one of forty-eight, one of fifty-four, one of sixty, and one of seventy hours' duration, and two which lasted seventy-two hours. In one case, wherein the coccyx was unyielding, the head of the child was on the perineum for nine hours, labor lasting thirty-six hours. Seventy-five of the cases reported were primiparous, the youngest being eighteen years of age, the eldest forty-one. The ages of the multipara ranged from "teens" to fifty years.

The above makes a brilliant showing in favor of "letting the woman have the child," but it would be incomplete without the following vigorous quotation:

"When I studied clinical midwifery, in 1851-52, in the Royal Charité of Berlin, the male students remarked that the clinics were tedious from November to April, as there were so few instrumental labors. The '*accoucheuse-en-chef*' consoled them by telling them to wait until summer, and she would provide them plenty of chances to see forceps used. I asked her how this could be? She simply said, 'I make these cases then.' And so it was. During the winter months, when the students in midwifery were young women, they were thoroughly instructed in the course of a normal labor, and in patiently letting nature do the work; consequently we seldom used forceps, and had very little childbed fever. When the sum-

mer came, and the young men students took the place of the young women, every third case was made a forceps case by untimely rupturing the membranes, or by other meddlesome interference with nature, which consisted chiefly in yielding to the *woman's* wish to put an end to her sufferings. Of course we now had plenty of interesting work, and were removed by whole wards to the isolated building in order to stop the spreading of fevers, purulent ophthalmia, and peritonitis. When, in 1853, I took the place as *accoucheuse-en-chef*, I followed a different course, teaching the young men minutely the mechanism of normal labor, showing them when and how to assist nature in case of an abnormal deviation, using for this purpose the manikin instead of the living woman, and not one single time were we removed to the isolating building during that summer."

The following, with reference to placental expressions, is of historic if not of obstetric interest:

"During the last four months of my holding the position as *accoucheuse-en-chef* in the Royal Charité of Berlin, Prof. Credé held the office of clinical professor, to which he was appointed after the death of Prof. J. H. Schmidt, my steadfast friend and teacher. Dr. Credé was ambitious for success *à tout prix*. During the winter preceding his appointment he acquired some notoriety in his efforts to gain renown by inventing a new—his own—method for delivering the placenta, the Credé Method. As soon as he had the direction of the *clinique* he taught practically, during his hour of attendance, what he had before taught theoretically; while I, during the other twenty-three hours of the day, very unwisely perhaps, not only discouraged the young men from following his method, but when teaching the midwives actually opposed his method.

"The Credé method has been followed by many of his pupils, and even gained some reputation in this country; but now Dr. Credé is making an effort to add to his fame, and this time it is by renouncing lately his

'method,' acknowledging it to be an error, and admitting that it may have been practiced to the detriment of many a woman."

To those of us who have been for ten years religiously practicing the Credé method this is cruel; but the most unkindest cut of all is, that the author does not condescend to mention that most recent measure of meddlesome midwifery, to wit, uterine and vaginal antiseptic irrigation.

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### Notes and Queries.

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EXTRA-GENITAL SYPHILIS IN MOSCOW.—Professor Pospéloff, of Moscow, has recently published in pamphlet form an account of the extra-genital syphilis which he has met with among the working-class population in Moscow. He has seen a great many more of these cases among women than among men, the actual figures being fifty-two male and one hundred and forty-six female cases, notwithstanding the fact that there are many more male than female patients in the hospital with which he is connected. The greater prevalence of this class of affection among women than among men is accounted for by the domesticated habits of the women, and more particularly by their receiving the infection during suckling. The most common seat of these non-venereal sores is the mouth. This kind of infection is mainly due to the dirty habits of the people, who habitually eat together out of the same vessel, and even with the same wooden spoon, which, if any of the persons using it are syphilitic, soon becomes a fruitful source of infection. Again, it is found that in small factories and sewing shops the workwomen very frequently suffer from extra-genital syphilis, showing that cleanliness and sanitary supervision are very defective. Prof. Pospéloff has collected a large number of references to the works of other authors in English, French, German, and Russian, which will be found in the appendix to the paper.—*London Lancet*.

**CINCINNATI LETTER.**—*Obstetrics and Gynecology.* Emmet's operation was performed by Dr. T. A. Reamy, Professor of Clinical Gynecology in the Medical College of Ohio, and Gynecologist to the Good Samaritan Hospital, Cincinnati, before the class at the Good Samaritan Hospital recently. He emphasized the fact that he did not insert first the stitch nearest the apex of the denudation, but the second and third from the apex. His experience had been that it was very difficult to tell just how much tissue you were taking and just how perfect the coaptation would be on inserting the highest stitch first. The doctor, after a thorough trial of all kinds of sutures, has settled down on catgut in this operation. He advises that a suture large enough to fill the entire tract of the needle be chosen. He advises the cutting of the thread long, as a short, stubby suture is more apt to get between the surfaces which are in coaptation and prevent their union.

The Medical Treatment of Dysmenorrhea was the subject of a paper before the last meeting of the Cincinnati Obstetrical Society by Dr. E. W. Mitchell, Professor of Internal Medicine in the Cincinnati Polyclinic. Remedial measures he divided into those of relief and those of cure. Of the former, opiates are the most powerful for relief and for evil. They should be avoided. Chloral, if used at all, should be with caution, because of the danger of forming the chloral habit. The prolonged use of the bromides in anemic subjects has a depressing effect on the general health, and under these circumstances is not good treatment. For the relief of the paroxysms they are of value, and may sometimes, as in spasmodic cases, be advantageously combined with belladonna or hyoscyamus. With cannabis Indica the writer had often obtained immediate relief, especially so in cases where the flow is free. Antipyrine is a valuable addition to our means of relieving pain. Tincture of cimicifuga and pulsatilla have both been found to give relief in some cases. Oxalate of cerium in six-grain doses has been recently recommended in fleshy, robust women with

scanty flow. Hygienic treatment is among the best of all curative treatments. Nutrition, exercise, healthful mental and moral surroundings are of the utmost importance. Young girls must receive special attention with regard to these matters, and all undue drains upon their vital forces, as too close confinement in school, at music or art lessons, late hours, and the dissipations of society must be discontinued. Local treatment is seldom necessary. The trouble in these cases is lack of development of the utero-ovarian system. The demands of our modern education and the excitements of "society" keep the demands of the brain and nervous system so active for nutriment that there has not been sufficient to complete the growth of the nervous system and sexual system. She now comes to perform an adult function with an infantile organ. The effort is imperfect and painful. The reproductive organs must be given a chance to catch up with the rest of the system in its development. Cases where neurasthenia or mal-nutrition are prominent are best cured if treated by a course of "rest cure," seclusion, milk diet, massage, and electricity. The existence of anemia usually indicates iron, and arsenic is valuable as a tonic. Electricity, both general and local, has rendered me good service. ApioI and manganese he believed to have some specific influence upon the utero-ovarian system. The binocide is probably quite as efficacious as the permanganate, and, being easier to give, is preferred. Of the eight cases reported, apioI, binocide of manganese, galvanism, and iron had given relief in cases uncomplicated with appreciable pelvic disease. When constitutional measures do not relieve, examination and dilatation, or other surgical measures indicated, should be made. The general practitioner is as prone to persist in medical treatment alone when surgery is needed as are some specialists to undue haste to examine and operate.

The removal of the second ovary is frequently a question of no little delicacy to decide. A case of this kind of peculiar interest was one which was operated upon by

Dr. T. A. Reamy, of Cincinnati, in his private hospital. True, it is becoming much more common now than formerly to perform the ovariectomy duplex; but the fact that the double operation has now become but little if any more dangerous intrinsically than the single one, this does not relieve us of the moral side of the question. A matter of no little difficulty is it to tell on inspection whether the second ovary shall be removed or not in a given case. It is not always easy to decide whether or not we have to deal with a beginning neoplasm which renders extirpation advisable, or whether there is merely an unusual development of follicles, on account of which the organ may be enlarged two or three fold. If there is no doubt of the presence of a neoplasm, the second ovary is, as a rule, to be extirpated. This, however, is only a plain statement, and is subject to many modifying circumstances. For instance, in the case of Dr. Reamy, just mentioned, the lady was young, intelligent, and wealthy. She was engaged to be married. She had been suffering intolerable pain for a long time, not only during the menstrual, but also the intra-menstrual period. As all the pain was in the left ovarian region, the promise was made the patient that the right ovary should not be disturbed unless positive evidence of disease presented on exposure. Yet her hearty consent was given to remove it if necessary. While no disease was found demanding the taking out of the ovary, yet to make sure of a thorough cure the temptation was to remove. The few moments' parley was fraught with importance. Dr. Reamy asked the advice of the gentlemen present. One would remove it; another would not remove it; the latter gentleman the proud father of three fine boys; still another inclined to a double operation, fearing a return of pain afterward. Dr. Reamy, after a few moments' careful consideration, allowed the ovary to remain, and the woman the right to become a mother as well as a wife. The case of Sir Spencer Wells is well known, where he was in doubt whether to remove both ovaries, where one had two cysts the size of a cherry.

The ovary was undisturbed, and the patient married, bearing four children. Schroeder, in cases where a new growth was recognizable and ovulation very desirable, resected the second ovary, allowing healthy tissue to remain, and closed the wound with a few stitches. It is probably not the removal of the second ovary which makes the operation any more difficult or dangerous, but rather the fact that the most unfavorable tumors, from an operative standpoint, are most frequently bilateral. If the desire is to abolish ovulation and menstruation, as for instance in fibroids accompanied by hemorrhage, then the second ovary should be removed, even though healthy. In the case of Dr. Reamy, just referred to, the left ovary and tube were removed. The tube was not occluded, but thickened and congested. The fimbriated extremity was adherent to the pelvic peritoneum, and the ovary was considerably atrophied. The cortex of the ovary was much thickened and unusually firm. This condition was so marked that Dr. Reamy thought it would offer reasonable explanation of the unbearable dysmenorrhea. Interference with the discharge of the Graafian follicle consequent upon the change he had often verified. He stated that the late Dr. James D. Hunter, of New York, had emphasized this view in a paper read before the American Gynecological Society in 1886. The patient made an excellent recovery. Dr. Reamy has had a case of laparotomy at his clinic at the Good Samaritan Hospital, before the students of the Medical College of Ohio, every clinic for four successive clinics, a fact which he says has not been equaled by any other college in America.

E. S. M'KEE, M. D.

CREMATION IN SOUTH GERMANY.—This substitute for the traditional mode of interment is gaining ground in Germany, and now the Communal Council of Munich are considering whether the time is not ripe for its recognition in practice. Eleven years ago the board of health of that city commissioned Dr. von Kerschensteiner to report on cremation, and the conclusions to which

he came were the following: In general cremation is not only to be permitted, but even to be recommended, especially after great battles; in certain cases (subject to official authorization) of epidemic disease, for the prevention of the transport of corpses, and in the case of soil conditions contra-indicating the inhumation of the dead. Munich, indeed, from the standpoint of public health is, Dr. von Kerschensteiner holds, under no special need of introducing cremation, but at the same time there is no ground for not permitting it, after official cognizance of the circumstances attending each individual case of death, and under certain determinate precautions. Of these latter, the first, according to Dr. von Kerschensteiner, must require the handing in, on the part of the responsible practitioner, of a complete medical history of the case—this report to be revised by the public medical officer in charge of the police regulation of dead bodies, and thereafter to be deposited with the judicial authorities. The second precaution must be the undertaking of a complete *sectio cadaveris* by a well-instructed pathological anatomist officially appointed for the task (the “*Städtische Prosector*”), and the deposition of his *post-mortem* report with the judicial authorities. Thirdly, there must be continuous numeration of the incinerated residue of each corpse, the checking such residue by a mark, and the deposition of this with its corresponding number for judicial purposes. These precautions and conditions are stringent, and the Communal Council of Munich contemplates no more than the optional sanction of cremation. Experience alone can determine their efficiency, whether they may not in some aspects be relaxed, or whether they may not be made yet more stringent. By that experience, say German sanitarians, the State will be guided in converting optional into compulsory vaccination.—*London Lancet*.

**UNEQUAL MYOPIA.**—A well-known physician relates the case of a person unequally myopic in his eyes, and very astigmatic in

the left one. On account of the bad images given by this eye for near objects, he was compelled in childhood to mask it, and acquired the habit when writing of leaning his head on the left arm so as to blind it, or of resting the left temple and eye on the hand with the elbow on the table. After putting on spectacles, when fifteen years old, he lost the habit of leaning. His two children, while they have not inherited the defect, have received his acquired habit, and have to be watched to keep them from hiding the left eye when writing. A somewhat similar case of inheritance of acquired habit is related by J. Jenner Weir, of a goat and its kids in the Zoö logical Gardens. A chain was attached to the animal's neck to keep him from jumping over the fence. He became accustomed to take the chain up by his horns and move it from one side to another over his back; in doing this he threw his head very much back, so as to place his horns in a line with his back. His offspring have inherited this habit, though it has not been necessary to put chains upon them.—*Popular Science Monthly*.

**COMPLICATIONS OF GONORRHEAL RHEUMATISM.**—A. C. Bornemann, of Copenhagen, has recently described the various forms of complication which are met with during an attack of gonorrhea, of which the symptoms are analogous to those attributable to rheumatism. The most common seat of so-called gonorrheal rheumatism is that of articulations; then follow the tendons, the periosteum, nerves, muscles, eyes, and lastly the pleura. The author's observations were based upon 278 cases of patients suffering from gonorrhea who came under treatment in the wards of the hospital at Copenhagen. In these patients the knee was affected 240 times, the foot 151, the shoulder 68, the metacarpophalangeal joints 52, the other articulations of the hand 51, the hip 46, the elbow 45, the jaw 12. The presence of increased amount of fluid in the synovial sacs was frequent, but not constant; for example, in the 240 instances in which the knee was affected the excess of fluid was noted 183 times. Affections of the tendons

and synovial bursæ occurred in 41 patients; four other patients suffered from periostitis; while there were three cases in which muscles were attacked. Out of this number of 278 patients the author met with two cases of endocarditis; gonorrheal ophthalmia was comparatively frequent, having developed in forty-five instances, and sciatica occurred five times. With reference to the question of the discovery of the gonococcus in the synovial fluid of a joint attacked with gonorrheal rheumatism, confirmation of the statement is still wanting. The author has found several times in the synovial fluid of the knee, after puncture, micro-organisms which do not comport themselves like gonococci. He believes them to be identical with the cocci found in the tissues invaded by suppurative processes.—*Medical Press and Circular*.

THE GRAPHIC ARTS IN MEDICINE.—On Friday, November 1st, a meeting was held in the large theater of the medical school of St. George's Hospital, with Sir Prescott Hewitt in the chair, to inaugurate a society for the encouragement of the pictorial and allied arts among past and present students of the hospital. In opening the meeting the chairman expressed his opinion of the extreme value of drawing and painting to the medical man, not only for the actual results produced, but also, if seriously followed, on account of the value of the training. He then related how his pre-medical career had been passed in a French studio, and how the training had developed his accuracy of sight, and of what great importance this had been to him in his surgical work. Referring to photography, he mentioned that its importance was becoming daily more and more recognized both in clinical and museum work, and reminded his hearers that modern photography owed its recent great progress to the enthusiasm of amateurs. Dr. Dickinson formally moved "that a society be formed in connection with St. George's Hospital for the purpose of encouraging sketching, painting, engraving, modeling, carving, photography, and the arts of representation in general." One of the ways in which it

was proposed to attain this end was to hold a meeting of the society at least once a year, at which members should exhibit any of their productions that could be included under the above headings. The meeting closed, after the election of officers and council, with a very cordial vote of thanks to Sir Prescott Hewitt for taking the chair, and the society is fortunate to have secured him as its first president. Past students of St. George's who may be desirous of joining the society are requested to send their names to Dr. Penrose, the honorable secretary, at the hospital.—*British Medical Journal*.

SACCHARIN is reported to be a valuable antiseptic. A strength of 1 to 500, as an addition to mucilaginous and other solutions, prevents the formation of low organisms. Thus a valuable, inexpensive dentifrice may be prepared by simply dissolving saccharin in water to the proportion of six per cent. A teaspoonful of this in a half pint of water forms an admirable antiseptic mouth-wash. In cases of malignant or other diseases of the stomach, requiring the washing out of that organ, a solution of saccharin of the strength of two per cent will be found very suitable.—*Boston Medical and Surgical Journal*.

BEER COMPARED WITH OTHER ALCOHOLICS. For some years a decided inclination has been apparent all over the country to give up the use of whisky and other strong alcoholics, using as a substitute beer and other compounds. This is evidently founded on the idea that beer is not harmful and contains a large amount of nutriment; also that bitters may have some medical quality which will neutralize the alcohol which it conceals, etc. These theories are without confirmation in the observation of physicians. The use of beer is found to produce a species of degeneration of all the organs. Profound and deceptive fatty deposits, diminished circulation, conditions of congestion, perversion of functional activities, and local inflammations of both liver and kidneys are con-

stantly present. Intellectually a stupor amounting to almost paralysis arrests the reason, changing all the higher faculties into a mere animalism, sensual, selfish, sluggish, varied only with paroxysms of anger that are senseless and brutal. In appearance the beer drinker may be the picture of health, but in reality he is most incapable of resisting disease. A slight injury, a severe cold, or a shock to the body or mind will commonly prove acute disease, ending fatally. Compared with inebriates who use different kinds of alcohol, he is more incurable and more generally diseased. The constant use of beer every day gives the system no recuperation, but steadily lowers the vital forces.

Recourse to beer as a substitute for other forms of alcohol merely increases the danger and fatality.—*Scientific American*.

**THE REMOVAL OF HAIRY MOLES.**—Hairy moles frequently occur upon the face or upon other exposed portions of the skin. Heretofore the removal of these blemishes has been effected by means of the knife, electrolysis, or caustics. The first and last methods are limited in their application by the extent of the mole. The second method is frequently tedious. A new procedure is to apply ethylate of sodium, one thorough application being sufficient. A bland ointment is used as a dressing, and the result is a very thin, flexible scar which is scarcely perceptible. Of course, the ethylate of sodium is applied to the patient only under chloroform, as it is exquisitely painful.—*Medical Chips*.

**SIMILIA SIMILIBUS.**—There is renewed trouble in the Woman's Homeopathic Hospital, of Philadelphia. Last year the staff resigned because they were not allowed to use other than strictly homeopathic remedies in strictly homeopathic doses. Now, it appears that the hospital is suffering from an acute attack of Christian science; and, as an indirect but effectual remedy, the pure Hahnemannians have had the leading faith curist arrested for practicing without being registered. Let the good work go on.—*Maryland Medical Journal*.

It is reported in the St. Louis Post-Dispatch of October 15th that a woman living in Fort Smith, Arkansas, seventy one years old, gave birth, on October 14th, to a well formed and healthy male child. Two years ago the woman, then a widow, married a young farm-hand employed by her. The case has caused a great deal of excitement among the neighboring physicians, and it will be thoroughly investigated.—*Medical and Surgical Reporter*.

**CHRYSAROBIN FOR HEMORRHOIDS.**—Dr. Kosobudskii speaks of this drug in high terms, but he differs with Unna as to the proportion to be used in the ointment employed. Dr. Kosobudskii uses two and a half per cent instead of five per cent of chrysarobin, as Unna prescribes. After washing the swelling with a two-per-cent lotion of carbolic or a one per-cent lotion of creolin, he applies the following ointment twice or three times a day:

Chrysarobini.....	gr. xj;
Iodoformi .....	gr. jvss;
Ext. belladonnæ.....	gr. jx;
Vaselin.....	5 jv.

M. et fiat ung.

Or a suppository may be made with cocoa butter. If bleeding be present, tannin may be combined in the above formula. Dr. Kosobudskii affirms that the pain, smarting, and bleeding will disappear in three or four days under this treatment.—*Medical Press and Circular*.

THE city of Brooklyn proposes to increase its supply of water by a ten-mile extension to Massapequa Pond, and has received bids for the work. The successful bids aggregate \$3,071,000, which exceed the estimates of the engineers. The largest excess over estimate is in a section where a very heavy iron pipe is necessary, and is due to the appreciation in the price of that metal.

PROFESSOR WM. PEPPER, of Philadelphia, will deliver the Middleton Goldsmith Lecture before the New York Pathological Society, in the hall of the Academy of Medicine, on Wednesday evening, January 15, 1890. The subject of the lecture will be Hepatic Fever.

*Editors American Practitioner and News:*

**ERRATA.**—In line second of aphorism 13, "Fifty Aphorisms on the Position of the Heart," appearing in the *American Practitioner and News* of December 7, 1889, read *lower* in place of *upper*. Aphorism 16 should read thus: The mitral valve lies behind the sternum, one inch from the fourth interspace. The figure is correct.

JASPER, IND., Dec. 11, 1889. E. J. KEMPF, M. D.

**CHOLERA.**—The epidemic of cholera which is now raging in Mesopotamia made its appearance on August 14th in Bagdad, and from there spread down the valley of the Tigris. One month later, September 15th, 5,393 deaths had been reported, and this figure represented only a small portion of the actual deaths. Numerous towns along the Karun River have been completely deserted. The latest and most authentic reports state that the disease is still on the increase, many towns along the Persian Gulf and the valley of the Euphrates having become infected.

THE leading homeopathic medical journal says that "as Hahnemann was responsible for the names (homeopathic and allopathic) which have divided the profession into sects, it would be proper for his followers and representatives to withdraw them if there is no occasion for their further perpetuation. [The regular profession has never accepted the label which Hahnemann prepared for it, and no doubt they would be pleased to have the homeopaths and their worshipers withdraw the opprobrious title.]

DR. BROWN-SÉQUARD is still actively engaged in experimenting with his "Elixir of Life," which he does not call by this term, however. He is very sanguine as to the ultimate success of the fluid, and intends shortly to publish the results of his investigations in the *Archives de Physiologie*.

THE corner-stone of an American hospital at Teheran was recently laid by the Minister of the United States to the Court of the Shah. The proposal to erect the hospital originated

with Dr. W. W. Torrence, of Teheran, and funds have been obtained partly by donations raised in America and partly by subscriptions in Persia itself, many distinguished Persians having made generous contributions.

MISS CLARA BARTON, the president of the Red Cross Association, left the Conemaugh Valley, October 25th, closing the greatest campaign the Red Cross has hitherto enlisted in. A public reception was given Miss Barton before she left, which was largely attended by all classes.

THE New York Board of Health decided, on November 19th, to resort to radical measures to rid the city of the stench caused by the manufacture of gas. The Board is prepared to carry its case into the courts.

THE seventieth birthday of Professor Bardeleben, of Berlin, was celebrated October 15th. A marble bust of the well-known teacher was unveiled in the garden of the Charité Hospital in Berlin.

ACCORDING to the latest advices, cholera continues to be epidemic in the Philippine Islands, although the disease is now on the decrease. The number of cases reported so far have been 22,397.

AUSTRIA is the only civilized country in the world that prohibits women from entering the medical profession.

**SPECIAL NOTICES.**

A ROTHROCK, M. D., McVeytown, Pa., says: I have prescribed Aletris Cordial in a case of threatened miscarriage. The woman had had three miscarriages in five years. Some six weeks ago she, being in her fifth month of pregnancy, was attacked with hemorrhage, bearing down pains, and all other symptoms of threatened miscarriage. I prescribed Aletris Cordial, which subdued the hemorrhage, bearing down pains, and all nervous symptoms that foreboded the old trouble, and at this time she promises fair to go to full term.

**INSOMNIA OF HYSTERIA:**

Peacock's Bromides.....4 oz;  
Celerina [Rio].....2 oz.

M. Sig: Teaspoonful every two hours until sleep is produced.











